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ALCOHOL DRUG ABUSE
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COMPLETED
ORIGINAL

ASSESSMENT INTERVIEWING FOR TREATMENT PLANNING

COURSE DESCRIPTION

PURPOSE

To teach counselors:

- The background and psychological information needed to assess a client
- To interview clients in order to get the information
- To write a case history based on the information
- To design individualized treatment plans

AUDIENCE

Treatment counselors in drug abuse treatment programs

NUMBER OF TRAINEES

Recommended optimum training audience size: 18; maximum 24

CONTENT

- The *Assessment Interviewing Guide* is divided into the four Rs: (a) Readiness, which assesses the client's reasons for being in treatment and expectations thereof; (b) Relationships, which assesses the client's relations with family, peers, and members of the same and opposite sex; (c) Rationality, which permits gross judgments regarding psychopathology, suicidal potential, and potential for violence; (d) Resources, which assesses the client's resources on which treatment can build.
- *Interviewing Skills* distinguishes interviewing from counseling and describes the components of a successful interview.
- *The Case History* presents a standard format for recording information gained from the assessment interview.
- *Treatment Planning* describes reasons for gathering the information, recording a case history, and planning a reasoned course of treatment for each patient.
- *Confidentiality* presents an overview of the issues to note to preserve a confidential relationship with the client and to maintain records.
- *Psychometric Tests* is an overview of personality, vocational, and intelligence tests that may be helpful for additional assessment information.

(continued on back cover)

PARTICIPANT MANUAL

ASSESSMENT INTERVIEWING FOR TREATMENT PLANNING

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***NATIONAL INSTITUTE
ON DRUG ABUSE***

***U. S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES***

PUBLIC HEALTH SERVICE

***ALCOHOL, DRUG ABUSE,
AND MENTAL HEALTH ADMINISTRATION***

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INTRODUCTION

PURPOSE

Federal funding criteria for drug treatment programs require that a treatment plan be developed that has both short-term and long-term goals for each client. In order to establish an appropriate treatment plan, it is essential that you adequately assess the client's strengths and weaknesses.

The purpose of this course is to train you to use a focused interview as the basis for assessing and understanding each individual client. Information obtained from the assessment interview will be used to develop plans for the client's individual treatment. In the context of this course, and for the sake of continuity of the concepts presented, it is assumed that assessment interviewing for treatment planning is *not* an intake process. Rather, it is conducted after intake as part of the client's orientation to the treatment program. Nevertheless some of the concepts, skills, and techniques taught in this course may have some value at intake in treatment programs that have central intake units.

COURSE GOALS

Numerous interviews with drug treatment staffs and mental health consultants in various programs yielded the overwhelming opinion that the National Institute on Drug Abuse could best help you by providing training in conducting a structured assessment interview. It was believed that such training should enable counselors in drug abuse treatment settings to —

- interview clients regarding their readiness for treatment, their interpersonal relationships, their rationality, and the personal resources that they bring to the treatment process;
- understand and conceptualize treatment as a dynamic process;
- make general clinical judgments of clients who may need additional services (psychiatric, legal, or social);
- organize information obtained from the interview in a case history so that it may be presented to treatment planning boards, to mental health consultants, or at case conferences;
- assist in the development of treatment plans that include long-term and short-term goals;
- understand the value of the assessment interview for individualized treatment planning;
- acquire skills in the area of focused interviewing for the purpose of treatment planning; and
- understand the intra- and inter-personal dynamics of the client that influence the treatment process.

COURSE RELEVANCY FOR IN-SERVICE TRAINING

Although it is not expected that this course will turn you into an outstanding diagnostician, it is hoped that you will become an integral part of the total treatment planning process. Also, it is hoped that the course will initiate or enhance in-service training in your program and therefore lead to more effective treatment planning and management. Continuing education is a critical component of any professional career. With this in mind, NIDA's Division of Community Assistance has encouraged Federally supported drug programs to initiate and develop an in-service training system. Specifically, it endorses a counselor training system that provides for weekly in-service training conducted by a supervisory counselor and/or mental health consultant.

Such a training system would allow the program to —

- individualize its training goals based on specific program needs;
- provide continuous training that reinforces effective cognitive and behavioral counseling skills; and
- provide training flexibility as counseling needs change.

ASSESSMENT INTERVIEWING LIMITATIONS

Ideally, the assessment interview procedures set forth in this course should be conducted after the client has been admitted to the treatment program. It is our assumption that the assessment interview begins with the first counselor-client contact. Also, it is assumed that demographic data (such as that on the Client Oriented Data Acquisition Process form or information obtained in medical screenings) will have been already collected. In addition to these two assumptions, there are certain limitations that should be noted regarding the assessment interviewing procedures presented in this course.

Time Constraints

Assessment interviewing is more an ongoing process than a series of concrete steps or stages. It must be realized that all of the information called for in the interviewing procedures will probably not be gathered in one or even two sessions. Time limitations and the client's readiness to participate may inhibit the interviewing process at first. (Readiness, in this regard, is directly related to the amount of rapport and trust developed between the client and you.) Since the ultimate objective is to acquire information in all four content areas covered by the assessment interview, the process is not concluded until enough information is obtained to ensure the development and implementation of an effective treatment plan.

Cultural Differences

It is also important to recognize that some clients may be reluctant to discuss some of the information sought during the interview. Such information often must be acquired piecemeal, in which case the treatment plan may require frequent revisions to incorporate new data. Having detailed or specific information regarding the client is not as important as acquiring information that pertains to the client's overall functioning and behavior. This

information is especially relevant for determining particular treatment modalities. To obtain the required information, however, it may be necessary to phrase specific interview questions to take into account both the client's cultural background and your style. The client's social and cultural milieu must be kept in mind to avoid conflicts during the interview, especially if your style of interaction differs significantly from the client's.

SUMMARY OF COURSE CONTENT

In designing the material in this manual, NIDA obtained assistance from various experts in the drug abuse treatment field. In an effort to ensure that the course will lead to the fulfillment of the objectives, professionals from various backgrounds were contacted. Those chosen to help develop the course had a conceptual understanding of client dynamics and clinical experience in treatment settings serving clients of diverse socioethnic origins.

After the experts were contacted, a task force was convened to draft an Assessment Interviewing Guide (AIG). The AIG was developed around four major content areas pertaining to a client's lifestyle and life history. These areas are: (1) client readiness for treatment, (2) client relationships, (3) client rationality, and (4) client resources. The content areas, termed the 4 Rs, offer an organized and systematic approach to conducting a focused interview. Using the shorthand 4Rs should be a good device to help the counselor keep these major areas in mind.

Each major content area of the AIG also contains subareas of inquiry. Sample questions within each area are provided. The AIG is located in the Appendices of this manual.

A rationale for each area of inquiry is presented in the body of this manual. The rationale was developed to provide you with an understanding of some of the concepts behind each of the content areas; it is also a means of helping you assess and understand the client's intra- and inter-personal dynamics.

In addition to the chapters covering the four content areas, there is also an extensive section on interviewing skills and techniques and several shorter chapters on case history documentation, treatment planning, confidentiality regulations, and psychometric testing. These chapters provide you with a structure for exploring each of the major content areas.

EVALUATION

The formative evaluation of this course was conducted in three stages; each stage contributed to the text and training design as it now appears. The first evaluation was an internal review of the course materials and training design through their developmental phases; this internal review team was composed of knowledgeable persons on the National Drug Abuse Center (NDAC) staff. The second review phase was conducted by an external review team comprising experts outside of NDAC and known for their expertise in treatment and the training of counselors. (See Acknowledgements section.) Each review resulted in revisions to the course before field trial.

The final evaluation stage, then, was a field trial of the course. The trainees were a good sample of the type for whom the course is intended. The conditions were characteristic of typical training situations. Two field trials were conducted — one in Jacksonville, Florida, and the other in Newark, Delaware. The field trials were a cooperative venture between the

state training support programs in the respective states and the NDAC. Trainees were recruited locally by the state training coordinator. There were eighteen trainees and three trainers at each site, following the recommendations for large-group delivery made for this course. Two of the three trainers at each site were counselor supervisors of local programs. The third trainer in each case was a trainer from NDAC who was not involved in the development of the course. Each training team had the qualifications recommended for persons training this course. Each training team was given a briefing on the course prior to the field trial deliveries. Each field trial was conducted in the same manner, using the *Trainer Tips* and training *Guidelines* discussed in the Trainer's Manual.

Of the 36 trainees who participated in the field trials, 24 were white, 10 black, and 2 Latino. Their average age was 28 years; 21 were male, 15 female; 11 had some college while 22 had a bachelor's degree or better. All but 5 were counselors or involved in direct client services, and the average length of time in their present jobs was 1.22 years. While this was not a "true random sample," there is no reason to believe that the trainees did not represent drug abuse counselors as a whole.

Parallel forms of pre- and posttests containing 60 items each were constructed to measure learning that occurred as a result of the course. The tests were related specifically to the training objectives and were designed to measure recall, interpretation, and application of knowledge. The average pretest score was 56 percent and the average posttest score was 71 percent, yielding an average learning gain of 15 percent. Statistical significance ($p < .05$) was obtained using correlated t-tests.

In addition to the objective tests, subjective measures were developed to obtain the participants' feedback on each session. Using a Likert-type scale of 1 through 5 (where "1" was "poor" and "5" was "excellent") participants were asked to rate various aspects of each session. They were also asked to comment freely on what they believed to be the most and least valuable aspects of each session. Using the Likert-type ratings, the course as a whole received an average score of 4.1. Participants typically reported that they liked the small group sessions most, and the mini-lectures least.

Trainee performance, trainee comments, trainer comments and observations made by the course developers resulted in minor modifications to the course after field trial.

Thus, the course as it now appears is a result of the above rigorous evaluation procedures.

ABOUT THIS MANUAL

While the format and content of this manual give it the appearance of a textbook, it is important to mention that the manual is *not* designed as a textbook. It will not provide you with everything you need to know about assessment interviewing. The content is aimed at providing you with an understanding of some of the basic psychological and interviewing concepts of assessment interviewing for treatment planning. Counselors interested in additional detail or different theories are referred to the bibliography.

This manual, then, is intended to be used during the 24½ hours of skills training that is the Assessment Interviewing for Treatment Planning Course. The manual supplements the training but is not a substitute for experiential learning. It is both a reference book and a workbook for the course.

The first half of the manual offers a brief explanation of the course content. The second half (the Appendices) contains the Assessment Interviewing Guide (questions only), sample interview notes based on the demonstration videotape, a sample case history outline, a sample treatment plan outline, and the confidentiality regulations.

Additional training materials such as Process Observation Feedback Forms, client sketches for simulated interviews, and a sample treatment plan will be handed out during the course of training as they relate to particular training activities.

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THE ASSESSMENT INTERVIEWING GUIDE

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THE ASSESSMENT INTERVIEWING GUIDE

ORIENTATION TO THE CLIENT

As mentioned earlier, this course is intended to help you assess and understand the unique set of problems, circumstances, and resources the client brings to the program situation. In order to achieve this understanding, techniques must be used that will enable you to elicit necessary information from the client in a focused, well-organized interview. The Assessment Interviewing Guide (AIG) was developed as one way of helping you determine an interview strategy by focusing on particular areas of the client's lifestyle and life history. This information can be summarized in a case history format from which an individualized treatment plan for the client may be developed.

Before the interview begins, it is important for you to recognize that the drug abusing population is composed of many different types of people. Not only do people abuse drugs for a multitude of reasons, but drug-dependent individuals have a wide variety of experiences as a result of drug abuse. Although there is often a tendency on the part of both professionals and nonprofessionals to speak of the "junkie" or "user" personality, it must be remembered that the client is a unique individual who is a product of *all* his experiences. What is *common* to these clients are the types of abuse and the effects of such abuse on their behaviors and lifestyles, and not any given personality disturbance or sociological condition.

When considering the psychology and sociology of drug abuse, however, one must be careful to distinguish cause from effect. Certain similarities in behavior or temperament that may seem to exist among all drug abusers are often the result of drug abuse, and may not be the underlying cause of it. It is known, for example, that certain drugs promote passivity and psychological dependency. It does not logically follow, however, that every drug abuser is a passive-dependent individual, or that passive-dependent types are good candidates for drug abuse. It is extremely important that this distinction be kept in mind if an appropriate assessment of the client is to be made.

Although individuals may abuse drugs for widely different reasons, it is still possible to talk about factors or conditions that may contribute or lead to drug abuse. Some types of abuse may be motivated by external pressures or conflicts exerted by the environment, while others may stem from internal conflicts within the individual.

It is essential to distinguish between internal and external pressures that contribute to drug abuse. It is also important for you to assess the client's relative strengths and weaknesses. Such factors may serve as indicators of potential success or failure in a given treatment program. It is often forgotten that varying degrees of emotional strength affect a client's ability to tolerate or resolve stress, whether of external or internal origin. Therefore, it is important that clinics have established criteria for assessing such strength in order to diagnose the severity of the client's problems, establish realistic treatment goals, and develop appropriate plans to achieve these goals.

Some individuals who abuse drugs primarily as a result of external pressures generally come from environments where such abuse is highly prevalent, condoned, or both. Although such an environment is more often apt to exist in low-income urban areas or other areas where the pressures of living are the greatest, they are not limited to such areas. There

are, for example, numerous users who come from correctional facilities, or from military duty areas such as Vietnam where exposure to drugs is much more likely and the pressures to take them much greater. It is interesting to note that the drug abuse behavior of users who were introduced to drugs while on duty in Vietnam was much less likely to continue after they were removed from the drug-conducive environment. Also, there are increasing instances of drug abuse in fairly affluent suburban areas by individuals who suffer from severe family or occupational pressures.

For those individuals who abuse drugs primarily as a result of such external factors as economic, family, or peer-group pressures, treatment may appear to be relatively straightforward, although it rarely is. Since these obstacles alone can severely hinder treatment, you must help the client identify other support systems that may allow him to overcome external obstacles. Ideally, the client should be taken out of high-pressure situations, but this is often impossible, especially when such pressures may be subtly exerted by the client's close friends or by his family. In these cases, you must help the client develop the resources to overcome such pressures and learn more effective coping behaviors to deal with stressful situations. The motivation of this type of client may be increased once he realizes that someone is willing and able to help him. Many counselors are highly successful in helping this type of individual resolve external conflicts. The resolution of such conflicts, in turn, may lead to a fairly rapid decrease of the client's symptoms with a corresponding improvement in behavior and attitudes.

Since not all drug abuse is generated by external or environmental pressures, you will frequently encounter clients with internal conflicts that contribute to their use of drugs. Many such clients may have personality disorders of varying degrees of severity. Careful history taking will often indicate that their drug abuse behavior is primarily a response to underlying personality or behavioral disorders that existed before the individual began to abuse drugs. Some of the disorders that such clients may have include self-destructive or acting-out behavior when frustrated, inconsistency in thought and behavior, strong dependency needs, and an inability to defer gratification or delay impulses. Individuals with such problems often fail to respond to a treatment program that has proven to be successful with others. Close examination of the reasons for failure often discloses that the client's personality disorder(s) and resultant behavior, along with an inability to cope with life's stresses, have defeated his and the counselor's rehabilitative attempts. Consequently, you must be prepared to deal with client behavior of this type and understand that progress may be slow. Treatment failures tend to reinforce whatever feelings of low self-esteem the client may already possess.

The counseling skills necessary to treat the individual described above require much more than being supportive or acting as the client's advocate. A reasonably accurate assessment of the client's rationality, along with the use of appropriate therapeutic measures (including chemotherapy), should be included in the overall treatment program.

Since the population of drug abusers constitutes such a heterogeneous grouping, more than one treatment and rehabilitative service may be necessary. The Federal Funding Criteria for Drug Abuse Services require that treatment plans be established for each client. If such treatment plans are to make sense, they must reflect individualization geared to the client's needs. This can be accomplished only through an appropriate assessment of the client's needs and resources. Such assessment aids in the development of treatment plans and also in the determination of the extent of counselor involvement and whatever other supportive services may be needed.

CONTENT AREA 1: READINESS

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CONTENT AREA 1: READINESS

Treatment, in the broadest sense, begins when an individual decides to contact a treatment program. At that time, he probably wants to change something in his life. He may be tired of hustling or may not be very successful at it. The habit may have become too large or drugs too scarce. He may "want out" of the dangers of drug use and supporting a habit. He may want to keep his family or his job. Or, he may simply want to stay out of jail. His reasons for change or the direction of the change may be unclear, but his appearance at intake usually indicates that he, or an important person in his life, has decided that a change is necessary.

Assessing a person's readiness for treatment is a vital step in the development of a treatment plan. Understanding why a person came to treatment, why he picked a particular program, and what his previous treatment experiences have been will enable you to see where the client is, where he wants to go, how he expects to be "cured," how he can get there, and what problems are likely to occur on the way. An assessment of readiness for treatment sets the stage for all treatment planning.

You must have an understanding of the many forces that bring an individual to treatment because those forces will ultimately determine his particular needs in and responses to the treatment program. A person's reasons or readiness for treatment are indicators of motivation. Clients with different motivations will behave and respond differently and need treatment plans tailored to their motivations.

Client expectations are another dimension of readiness for treatment. The more realistic a client's expectations, the smoother the course of treatment is likely to be. You need to be aware of what the client expects to achieve in the program, what he expects to do, or what he expects to have done to him. Some clients may need to be educated as to the nature of the treatment involved. Attitudes about three-week "cures" (i.e., methadone detoxification) often must be overcome if the client's long-term goal is to remain drug free.

A client's previous drug treatment experience influences his current readiness for treatment. In general, the same kinds of problems encountered in one program may be transferred to the present program. Treatment components the client believes to be of value to him should be identified as well as areas of potential difficulty. This kind of information may give you a head start in developing treatment plans.

A. What brought the client to treatment?

Rationale:

Before any kind of treatment planning can be initiated for a given client, it is necessary to get some idea of the various forces that prompted him to seek treatment. Depending upon the factors involved in a particular situation, a client may or may not possess sufficient motivation for active involvement in the treatment process. Thus, the above question not only helps in ascertaining the underlying motivation for the client's presence in the program, but in addition, provides a predictor of special problems that may greatly influence treatment planning and management.

The reason an individual comes to treatment often indicates to you what other relationships may have to be initiated, maintained, or terminated. A referral from the courts, a private physician, or employer may specify that you maintain a relationship with that referral source. Relationships may need to be developed with family, probation officers, employers, welfare workers, or teachers in order to implement and follow up on treatment plans. Relationships the client has with "friends" that are of a nonproductive nature may need to be terminated in order for the client to progress in treatment.

If the push for treatment comes from a spouse or other family members, these people may need to be included in the treatment process. Marital counseling, family therapy, parent effectiveness training, home management counseling, or similar adjunctive treatment measures may be indicated. In cases in which an individual other than the client is involved, however, it is necessary to remember that the consent of the client may be required in the form of a written release authorizing treatment personnel to obtain information from pertinent (and specified) individuals. Confidentiality of client information is discussed in another section of this manual.

The nature of the client's involvement in the treatment program (i.e., whether it is of voluntary or mandatory nature) and the extent of such involvement are extremely important dimensions to be considered in treatment planning. If a client is enrolled in a treatment program primarily because of external pressures applied by legal, family, or other social forces, then the planning and management of the treatment process may be different than if the client has an active interest in making personal changes in his life. For example, many drug abusers are in treatment programs solely because of pressures exerted by the courts and very frequently lack the inner drive to make any major changes. Under these circumstances, clients more often than not enter the program with the attitude that they are "doing time" and, therefore, assume the posture of a passive recipient with respect to the treatment process. Such clients may not, for example, be good candidates for intensive group or individual counseling. Treatment for this type of client could initially center more on low-key programming such as seminars or socialization through the development of casual relationships with various treatment personnel in the program.

In the case of clients who are unable to assume an active role in the treatment process due to severe psychological disturbances, an entirely different approach might be necessary. Under these circumstances, supportive individual and/or group counseling that is nonthreatening to the client may be appropriate. The type of counseling employed will depend upon the client's particular disturbance and his willingness to participate in the treatment program. Providing the client with treatment appropriate to his particular situation may greatly facilitate his becoming involved in the treatment process.

Asking the client *why now* is important. Those experienced in the helping professions have found that specific inquiry into the current reason that propels a person to seek treatment is important in identifying the underlying motivation for treatment.

For example, if the client's spouse has given the client an ultimatum that he will change his lifestyle or face divorce, we have a reasonable indicator of motivation. At the very least, such a situation would represent a disruption in family function, if not a full-blown family crisis. The real intent of the message must, therefore, be determined, along with its potential impact on the treatment process. The spouse might be interviewed to ascertain if the threat is genuine and to assess the client's understanding of the situation.

Inquire about:

1. Family pressure
 - a. *In what ways has your spouse or family influenced you to seek treatment?*
 - b. *What does your family think about your being here?*
2. Legal pressure
 - a. *Were you sent here by the courts?*
 - b. *What, if any, legal pressures are bringing you to treatment?*
3. Peer pressure
 - a. *Have any of your friends been in treatment here?*
 - b. *Have any of your friends been in other treatment programs? Which programs?*
4. Street pressure
 - a. *Is something happening on the street drug scene that causes you to be here?*
 - b. *Did you come here for reasons of personal safety?*
5. Job pressure
 - a. *Were you sent here by your employer?*
 - b. *If so, What kind of progress do you have to show in treatment in order to keep your job?*
6. Medical problems

What medical problems brought you to treatment now, if any?
7. Internal pressure
 - a. *Did you decide to come to treatment on your own?*
 - b. *What were the reasons for your decision?*
8. Immediacy
 - a. *What caused you to seek treatment now rather than earlier?*
 - b. *What has changed?*

B. What brought client to this program?

Rationale:

First of all, it is important to know the client's general expectations regarding treatment. A client's skepticism about the program, resulting from being coerced to attend or from seeing it fail in the case of other drug abusers, will lower his expectations and greatly impair his motivation. On the other hand, the client's expectations may be too high; he may have heard about "magical cures" effected through medication or counseling. Unrealistic expectations of a quick and easy cure must be corrected; they will quickly lead to disillusionment and discouragement and therefore greatly impede the client's progress. Consequently, it is crucial to ascertain the client's motivation for seeking treatment in terms of his overall expectations, if treatment is to be planned and carried out in an effective manner.

It is also important to understand the reasons that a person selected a given type of treatment. Why did the client choose detoxification over methadone maintenance or a therapeutic community? Why was a woman's program selected instead of a coed center? The source and accuracy of the information shapes the client's expectations. A client who enters treatment because he saw his street buddy straighten up exhibits a dynamic that should be capitalized on in treatment planning (i.e., a "buddy" or "big brother" system could be used). On the other hand, the client who joins a methadone program along with his street gang simply to get a sure "fix" when things get rough on the street, is responding to a very different kind of peer influence. Probing a client's reasons for selecting a program may also provide an opportunity to explore alternative modes of treatment that may be more acceptable or appropriate.

The nature of the support for the client's decision to enter treatment is also important. A husband who is dead set against methadone will not encourage his wife's daily trips to the clinic. The attitudes of the significant others in the client's life may determine how long treatment will last. Thus, you should give high priority in determining which significant others, if any, can be helpful or harmful in motivating the client to change for the better. It is also important to determine what type of intervention with these significant others would be helpful in developing and maintaining nondrug using behaviors in the client. You might decide that the wife, husband, parent, or significant other needs to be educated as to the nature of substance abuse and treatment if the client is to succeed.

Inquire about:

1. Preferred modality

What type of treatment do you expect to receive here?

2. Source of information regarding modality

How did you learn about our program?

3. Expectations

a. *What are your expectations regarding the treatment methods utilized in this program?*

b. *Given what you know about the program, what do you anticipate will give you the most difficulty?*

c. *How long do you expect it will take to get straight? or How long do you expect to be here?*

d. *What do you expect it will be like for you next week? Next month? In six months?*

e. *What do you expect you'll be like (behavior) when you are ready to leave treatment?*

4. Sources of expectations (personal contact, friends, rumor)

a. *Where do your expectations come from?*

b. *What did friends tell you?*

5. Attitudes, beliefs, fears

- a. *What have you heard about this treatment method?*
- b. *What do you know about other forms of treatment?*

6. Acceptability

- a. *Is this form of treatment acceptable to you?*
- b. *What other treatment did you consider?*

7. Support for client's decision

- a. *How do friends (spouse, significant others) feel about your decision?*
- b. *What things are working against you to prevent treatment?*
- c. *What things are working for you?*

8. Do significant others have an interest in keeping the client dependent?

- a. *Who do you think really cares about what happens to you?*
- b. *How are things and people going to change once you stop using drugs?*
- c. *What changes do you anticipate in your relationships with your spouse (with others) if you stop using drugs?*

C. Has the client had previous treatment experience?

Rationale:

If a client has had treatment in the past, it is important to find out what aspects of the previous treatment experience were helpful or harmful.

The attitudes a client has about previous treatment experience will most likely be an influence in his relationship to the present treatment plan. As mentioned earlier, the same kinds of problems experienced in one treatment modality may be transferred to the new program. Generally, an understanding of prior failures may help avoid future failures.

Similarly, an understanding of prior successes may help guarantee success in the future. An awareness of previous difficulties and successes may enable you to anticipate, deal and help resolve problems more easily when and if they occur.

Questions about the nature of the previous termination can provide considerable information as to the kinds of conflicts that might arise in the new program. In some instances, past issues surrounding termination can form barriers that continue into the new treatment modality.

Additionally, there may be legal reasons for wanting to know past treatment experiences. For example, previous failure at other detoxification attempts is required for anyone under 18 years of age to enter methadone maintenance; a 30-day period must intervene between attempts at detoxification.

Inquire about:

1. Previous attempts at treatment

What previous treatment have you had for drug abuse, if any?

2. Modality

What was the nature of the treatment?

3. Sequence of experiences (if more than one prior experience)

4. Duration

How long did the treatment last?

5. Consequences

a. *What was it like?*

b. *What changes did it bring about?*

6. Satisfaction

What did you like about the treatment?

7. Dissatisfaction

What did you dislike about the treatment?

8. Reasons for termination

What were the reasons or circumstances for leaving?

9. Who or what was helpful to the client in these programs?

a. *In what way did you find the counselor to be helpful? Not helpful?*

b. *What about the experience did you find helpful? Not helpful?*

c. *What did you gain from the experience?*

If the client gives negative response:

How did you handle it? or What did you do with your anger, hostility, disappointment (or whatever client said)?

d. *What services in the last clinic helped you most? Least?*

CONTENT AREA 2: RELATIONSHIPS

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CONTENT AREA 2: RELATIONSHIPS

In attempting to bring about change in a client's behavior, many drug treatment programs rely heavily on socialization processes. It is therefore necessary to know something about the client's ability to relate to others in his environment. Is the client capable of forming lasting relationships? Does the client have many friends? Is close friendship a real possibility for him? How does he relate to others in a group situation? Is he easily influenced by others or does he tend to be an independent thinker? These are some of the dynamics that need to be explored if the treatment goals are to be met.

Understanding how the client relates to others, both family and peers, same and opposite sex, on a one-to-one basis, and in group situations provides some indication of the preferred treatment modality and the types of problems that could be expected to arise during the course of treatment. A client's capacity for forming lasting relationships and the interpersonal dynamics involved in one-to-one relationships may be an important predictor of his behavior in the clinic setting in terms of how he will relate to individual staff members.

Conversely, his style of interaction with the treatment staff may often reveal specific problems in forming or maintaining interpersonal relationships with others outside the program. Some drug treatment programs have found that their clients frequently exhibit difficulties in forming and/or maintaining close human relationships. The client may assert that his relationships with others are good; but there is often considerable evidence during the interviewing and throughout treatment that he lacks the ability to function adequately in interpersonal situations. This inability may result from a number of factors, including the presence of long-established patterns of interaction (dynamics) that disrupt the maintenance of close personal ties. For example, a client may make unrealistic demands upon significant others in his life, or he may hold unreasonably high expectations regarding their roles and obligations in relation to him. Such individuals may readily form relationships, but may have great difficulty maintaining them because of the unrealistic demands placed on those with whom they are close.

There are still other clients who have never had a meaningful human relationship. They are basically loners who feel that they neither need nor want close relationships, or they experience great difficulty in establishing them. Such clients, as a defensive measure, will often reject that which they feel they are unable to attain, and they are apt to cloak their rejection in cynicism toward human relationships in general. These individuals often pose a problem in terms of prognosis and treatment because they are likely to be mistrustful of other people's intentions and abilities. Such mistrust can and frequently does lead to antagonistic and counterproductive behavior in treatment. This may be particularly true for those clients who have been coerced into attending the treatment program.

Understanding the client's personal relationships is of great value in determining whether significant others need to be considered in treatment planning and in the determination of the roles that such individuals might play in the overall treatment process.

In addition to knowing what kinds of relationships the client has with significant others, it is important to know how those relationships affect his behavior. Knowing the effect of significant others is extremely valuable in helping you understand external pressures that influence the client.

Finally, having an understanding of the client's dynamics in relating to significant others both on an individual and group basis may help influence the treatment plan. It follows that a client with a history of inability to form lasting close relationships with an individual or within a group may require a treatment plan with very limited nonstressful encounters and low-key programming. It may be a significant initial accomplishment that this individual successfully attends a clinic daily to receive methadone. Demanding that such a client attend intense encounter group sessions may result in his leaving the program. It would also seem inappropriate to assign a male client who respects aggressive males and manipulates women to a woman counselor who is inexperienced in treating such a client.

A. Who is (are) the person(s) to whom the client has been closest?

Rationale:

An inquiry into the client's relationships with significant others may indicate outside support or interference, as well as provide you with some idea of the client's style of interaction. The following items were developed to assess both the quality and depth of relationships that the client currently has or has had with these people. In addition to questions concerning the status of such relationships and the client's feelings toward them, there are items designed to tap client dynamics that might prove useful in treatment. Such areas include the amount of trust and confidence displayed by the client in the relationship, his ability to work out problems and resolve disagreements on an interpersonal level, and the extent to which the other person in the relationship can be relied upon for support.

Inquire about:

1. Quality of the relationship
 - a. *Who is the person you feel closest to?*
 - b. *Tell me about this person.*
2. Feelings about the person and the relationship
 - a. *How do you feel about this person?*
 - b. *What do you like best about the relationship?*
 - c. *What do you dislike about the relationship, if anything?*
3. Duration of the relationship
 - a. *How long have you known each other?*
 - b. *How long have you known each other on a close or intimate basis?*
4. Present status
 - a. *Do you associate now?*
 - b. *Do you keep in touch?*
 - c. *How are you getting along now?*

5. Meaningfulness or depth of relationship

- a. *What do you do together?*
- b. *What do you talk about?*
- c. *Have you ever told this person things about yourself that no one else knows?*
- d. *When (or if) you are in trouble, will this person help you out?*
- e. *How do you handle disagreements?*
- f. *Are there some secrets that you can trust this person with?*
- g. *Are there some secrets that you cannot trust this person with?*
- h. *Are there some things you can depend on this person for? Not depend on him for?*
- i. *Can he trust you?*
- j. *Can he depend on you?*

B. What is the quality of the client's relationships with members of his family?

Rationale:

Family interactions are often important in determining drug abuse behavior; patterns of abuse and abstinence may be related to intrafamilial conflicts. Consequently, it is necessary to find out which family members are most likely to be involved in these kinds of interactions. Also, some family members may wish, consciously or unconsciously, that the client remain drug dependent and, thus, may greatly interfere with the client's progress. In such cases, it may be necessary to determine if other members of the family should be included in the treatment program.

The capacity for developing close relationships can often be understood in terms of the various relationships that a person has developed within the family during his formative years. These early relationships are often neglected in history taking but are extremely important for understanding how a person might function in therapeutic situations. The questions developed for this section are, therefore, primarily concerned with examining the nature of the family (i.e., whether or not it is an extended family) and the type of relationships involved, along with the quality of the relationships the client has with the various family members.

Inquire about specific family members:

For all of these, say *Tell me about your*

- a. *Mother (natural, foster, step)*
- b. *Father (natural, foster, step)*
- c. *Siblings (natural, foster, step)*
- d. *Other family figures (grandparents, aunts and uncles, godparents, etc.)*
- e. *Spouse*
- f. *Children*

C. What was (is) the home like for the client?

Rationale:

The quality of the client's home environment as well as his status within that environment provides you with information applicable to the program-client relationship. If, for example, the home environment was a happy and supportive one, then the client is more apt to be willing to enter into positive relationships in the treatment setting. If the home environment was an unpleasant or rejecting one, the client may be reluctant to establish any meaningful relationships with you or other staff of the treatment program.

It is important that you obtain information regarding specific conditions within the family. These conditions include, in addition to unusual family constellations, such things as drug abuse, alcoholism, unusual or atypical forms of sexual behavior (e.g., incest), child abuse, criminal activity, and mental illness. Such conditions can exert a marked negative influence on the client's ability to interact successfully with others and can also pattern his style of interaction. For example, a male client who observed and learned as a child that his father coped with stress by excessive drinking may use a similar coping mechanism when experiencing conflict and anxiety. Also, it is important to discover whether those family members exhibiting adverse behaviors served or still serve as role models for the client.

Another aspect of the client's home environment centers around issues related to unresolved feelings about the losses of major figures in the client's life. It is important to assess the way in which an individual handles separation and grief. The issue of separation will eventually arise in the clinic setting. For example, some clients who experience separation anxiety may become severely disturbed when their counselor goes on vacation if they have a good relationship with the counselor. Breaking a dependent pattern (such as drug use) may also produce counterproductive separation anxiety. The client may experience extreme psychological discomfort in such situations and may even revert to former patterns of behavior.

One way to detect the client's ability to handle grief is to inquire directly regarding family members. A client may, for example, get tears in his eyes when one of his parents is mentioned; it may be clear that he has not really worked through feelings associated with the death or disappearance of that parent. You need to be particularly sensitive to the historical significance of the separation. In the case of the individual who was rejected by his parent(s), a reaction may occur in which the client rejects the parent. In turn this rejection may be transferred to others (for example, you). In the latter situation, the client may be relieved by your absence or his release from the program. In order to develop an appropriate treatment plan for the client, it is important to keep such factors in mind when assessing the impact of separation on him.

Inquire about:

1. Family

- a. *What were some of the positive things you got from your family?*
- b. *What were some of the negative things you got from your family?*
- c. *Did your family treat you differently from your brothers or sisters? In what way?*

- d. *As a child, were there ever times when you wanted to run away from home? Did you? What were the reasons for your leaving?*

2. Adverse family conditions

- a. *Drug abuse*
- b. *Alcoholism*
- c. *Brutality, child abuse*
- d. *Incest or other unusual sexual behaviors e.g., pedophilia*
- e. *Suicide*
- f. *Mental illness*
- g. *Compulsive gambling*
- h. *Compulsive promiscuity*
- i. *Criminal behaviors*

3. Unusual family constellations (homosexual or bisexual parents, communal parents, open marriages, etc.)

4. Separation

- a. *Have you ever lost someone who meant a lot to you through —*
 - 1) *death,*
 - 2) *murder,*
 - 3) *suicide,*
 - 4) *divorce or separation,*
 - 5) *incarceration of brothers, sisters, or parents?*
- b. *As a child, were you ever separated from your family due to —*
 - 1) *illness,*
 - 2) *long periods of hospitalization, or*
 - 3) *other institutionalization? e.g., detention facilities, training schools, etc.*

D. Was the client ever separated from his family and institutionalized as a child?

Rationale:

Some individuals may have spent the majority of their formative years in an institutional setting rather than in a family environment. In these cases, special attention may need to be given in assessing the client's ability to successfully relate to people and to the treatment program. You need to know both the type of institution involved and the attitudes the client has toward persons within that setting. A client raised in an institution is apt to be more positively influenced by his peers and negatively influenced by authority figures. This is particularly true of clients raised in facilities where staff members saw their role as being primarily of a disciplinary and controlling nature. People in such facilities are generally forced to rely on their peers for both emotional support and the development of a positive self-image.

Deviant behavior can often serve as a means of achieving status in the eyes of one's peers: in such a setting one is frequently under pressure to be "with it" and to do what everyone else does. In some cases, then, a client's first introduction to drugs may have occurred in an institution.

Clients who have had negative experiences in an institutional setting may actively avoid any and all relationships with treatment personnel. There may be active resistance or defiance on the part of the client in an effort to prove that "he doesn't need anyone," that he can get along "just fine" without help.

You may find it helpful to determine whether the separation of the client from his family was involuntary on the part of the family (i.e., the child was removed from the home), was voluntary on the part of the parents (i.e., the child was rejected by the family), or was voluntary on the part of the child (i.e., the child ran away or requested removal from the environment). In each of these situations, the client's reactions to the separation may be different. In the situation where the client was wrested from his home, a different set of dynamics may be operating than for the client who requested removal. In cases where a client had been institutionalized in his early years, care needs to be taken to set up a treatment plan that takes the above factors into consideration.

If the client lived in an institution, inquire about:

1. Nature of the institution

What kind of an institution or facility was it?

2. Reasons for placement

- a. *Who was responsible for your being in the institutions? courts, family, self, others*
- b. *Why were you placed there (or why did you choose to go there)?*
- c. *Did you feel your placement there was the right thing for you?*
- d. *How do you feel about the people responsible for your being there?*

3. Length of confinement

- a. *At what age did you enter the facility?*
- b. *How long did you remain there?*

4. The client's attitudes towards the facility and its personnel

- a. *What were some of the things that you liked about the facility? Disliked about it?*
- b. *What were your feelings toward the people who ran the facility?*
- c. *What people were the most important to you in the institution? In what way did they contribute to your well-being or development?*
- d. *How would you describe your feelings about institutions in general?*

5. Adverse conditions

- a. *Drug abuse*
- b. *Brutality and/or harsh treatment by authorities*

- c. *Violence on the part of peers*
- d. *Homosexuality*
- e. *Physical conditions, e.g., poor accommodations, harsh practices, etc.*
- f. *Mental illness and/or suicides*
- g. *Runaway and turnover rates*
- h. *Relationships with peers, that is, was client accepted or rejected by peers?*

E. What is the quality of client's relationship with members of the same and opposite sex?

Rationale:

The differential relationships of individuals regarding male-female preference may have important implications with respect to the selection of counselors for a given client. For example, a client who is fearful of or antagonistic toward males should probably be assigned initially to a female counselor.

The success of rehabilitation or treatment may depend in some cases on the person's ability to relate successfully to members of the opposite sex and to form meaningful same-sex relationships that are not bound up with self-destructive or criminal behavior. In some instances, drug abuse may be the outgrowth of current or past sexual conflicts that the client has not been able to resolve or handle effectively.

In addition to ascertaining the client's overall orientation to members of the same and opposite sex, it is quite useful to obtain information concerning his attitudes toward long-term relationships of a sexual nature such as marriage. Knowing the individual's marital status and attitudes toward marriage can provide you with some understanding of the client's relationships with and attitudes toward each of the sexes. A client who has problems relating successfully with members of the opposite sex also may be having a particularly difficult time with his marriage. Such problems, if severe, may lead to compensatory behavior such as drug abuse, alcoholism, compulsive promiscuity or other activities that may get him in trouble.

Inquiring into this area of the client's life may be uncomfortable and embarrassing to both you and the client. The appropriateness of this line of questioning often depends on timing, the client's readiness to reveal himself, the quality of the relationship between you and the client during the interview situation, and on cultural differences. You are thus cautioned to proceed as sensitively and directly as you can.

Inquire about:

1. People of the *same* sex
 - a. *Do you have many male (female) friends?*
 - b. *On the whole, do you enjoy being with men (women) more than women (men)?*
2. People of the *opposite* sex
 - a. *How do you get along with men (women) in general?*
 - b. *Which of the sexes do you get along with better? For what reasons?*
 - c. *With which do you spend the majority of your time?*

3. Sexual orientation

- a. *What is your major sexual orientation? gay, straight, bisexual*
- b. *What kind of a person do you prefer as a sexual partner?*
- c. *How important do you feel sex is in comparison with other aspects of a relationship?*

4. Marital status and attitudes

- a. *Are you married or living with someone? If yes, How do you feel about your marriage (or relationship)?*
- b. *Have you been married (or lived with someone) before? If yes, How many times? What caused the marriage(s) (or relationship(s)) to end?*
- c. *What are the things you like about being married (or living with someone)? Dislike?*
- d. *What do you feel is the most important factor that holds a marriage (or relationship) together? e.g., love, good sex, getting along well, similarities in taste or temperament, social influences, etc.*

F. Has the client ever belonged to social or institutional groups?

Rationale:

The client's ability to relate meaningfully to social or work groups is an important predictor of success in the treatment program. Since most treatment programs are institutional in structure and frequently involve small-group dynamics, the client's ability to function in such settings will be greatly influenced by previous experiences with group situations.

Clients without prior success in group settings (such as church groups, work groups, school situations, sporting teams or clubs) may require low-key programming that will not place them in socially stressful situations, that is, low-key programming that does not require major social interaction. An important element in a treatment plan for such persons is to provide early opportunities for group affiliation that are not very demanding in terms of performance or level of participation. This may also hold true for clients who have never had close relationships of any kind.

On the other hand, for those individuals who spent their formative years in institutions, group experiences may not have positive transfer value. Such individuals may have acquired hostile and rebellious attitudes toward any type of group setting or arrangement. In extreme cases, their aversion may become so great as to cause them to avoid *all* group situations. For these clients, attempts to exert external influence through group pressures should be approached with caution as they are apt to reinforce the clients' feelings of hostility and resistance.

Assessing the client's group involvement also enables you to determine to what extent he may be influenced by and dependent upon others. The individual with a high need for group acceptance may be much more susceptible to pressures exerted by both authority figures and peer group members. The person with low need for group acceptance tends to be less influenced by external pressures and may actively resist group pressure.

In situations where the client appears to be more independent, care should be taken to determine whether this results from a genuine feeling of self-confidence and self-sufficiency, or whether it results from an inability to relate successfully to others. The loner who asserts that he neither needs nor wants the help or opinions of others may be saying that because he is unable to form and maintain close relationships with others. In any event, treatment plans need to include strategies designed to help the client cope effectively in such situations. This may be of particular importance to the client later when he is required to enter job or living situations that generally require some cooperative group arrangements.

Inquire about:

1. Membership in special groups

Have you ever belonged to —

- a. *church groups,*
- b. *community groups,*
- c. *school groups (extra-curricular activities),*
- d. *street gangs or social clubs,*
- e. *political groups,*
- f. *sports clubs,*
- g. *military groups,*
- h. *therapy groups?*

If yes for any one or more of the above, inquire about:

2. Membership status

- a. *How long did you belong to that group?*
- b. *How often did you attend meetings or get-togethers?*

3. Role in group, i.e., leader or follower

- a. *Where did you fit into the group?*
- b. *What did you do?*

4. Extent of group involvement

- a. *Did you work cooperatively with others toward a group goal?*
- b. *Did you pursue your own interests with little interest in activities of other group members?*

5. General attitudes toward group affiliations

Do you prefer to spend most of your free time alone, with one other person, or in a group?

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CONTENT AREA 3: RATIONALITY

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CONTENT AREA 3: RATIONALITY

The presence of a severe psychological disturbance in clients is one of the single largest reasons for the failure of drug abuse treatment. When clients fail to respond as expected to the program's treatment, one possibility that should be examined is that of an underlying psychopathology. The presence of a severe psychological disturbance, however, does not mean that the patient is untreatable. What it does mean is that the usual drug treatment plan must be modified to take these conditions into account. Fortunately, there are now effective treatments for many types of psychological disturbances (such as chronic depression and some psychoses). If these problems are effectively treated through psychiatric consultation and/or psychotropic drug treatment, the patient can frequently be maintained within a traditional drug program; treatment can proceed as with other clients.

The client's drug abuse history sometimes greatly complicates the treatment of the psychological difficulty. For example, a client may be subject to extreme changes in mood that are sufficiently severe to warrant a diagnosis of manic-depressive illness. Even though this disturbance is now treatable with Lithium, the client's unpredictable use of other drugs may make the prescription of Lithium too hazardous. There are, therefore, some cases that cannot be successfully managed in a routine drug treatment program and may ultimately require referral to a psychiatric treatment facility.

This section is not intended to train you to make psychiatric diagnoses nor to make sophisticated clinical judgments. As stated above, it is not uncommon for severe psychological disturbances to go undetected in many treatment programs. This usually results in treatment failure for the client or intense feelings of inadequacy for the counselor. Either of these lead to counselor "burn out." If, during the course of the assessment interviews, you sense that the client may be psychologically disturbed, you should seek another opinion. This section is intended to help you detect such pathology in order that appropriate measures can be taken either to modify the client's treatment plan or to refer him to a mental health specialist.

A. Has the client ever demonstrated extreme mood swings?

Rationale:

These questions are designed to identify the presence of severe mood swings such as those that occur in manic-depressive illness or in severe depression. Periods of extreme elation not associated with a drug experience may be as pathological as periods of depression. The presence of severe mood disturbances indicates the need for referral for further psychiatric evaluation and perhaps initiation of psychiatric treatment. Fortunately, the affective disturbances (both depression and mania) are treatable and sometimes even constitute the underlying reason for the drug abuse.

Inquire about mood swings:

1. Depression

- a. *You felt really down? What kinds of feelings did you have? helpless, hopeless, depressed*
- b. *You lost your interest or pleasure in things that you usually enjoy?*

- c. *You lost your ability to concentrate?*
- d. *You felt physically down? fatigue, headaches, digestive disturbances, etc.*

2. Mania

- a. *You felt really hyped up — as if your mind or body were speeding?*
- b. *Everything seemed really rosy?*
- c. *You went on binges? eating, spending, sex, gambling*

3. Mixed — Either Depression or Mania

- a. *There were changes in your sex drives or behavior? What kinds of changes?*
- b. *There were marked changes in your eating habits or in your weight? What kind?*
- c. *You had dramatic changes in sleeping patterns? What kinds of changes?*
Inability to fall asleep, early morning awakening, no need for sleep

NOTE: If the client answers yes to any of the above, also inquire: *How long did it last? Did it get progressively worse? How were you able to stop it? Is this a problem at this time?*

B. Is the client suicidal?

Rationale:

The assessment of suicidal potential has two concerns. First is the determination of an immediate risk of suicide. The suicidal patient may need immediate crisis-oriented care. The second concern is with the assessment of the client's potential for harming himself should the situation of loss, rage, or strong affect occur during treatment. Since such reactions generally do occur during treatment, this is an important factor to take into consideration.

Sometimes counselors are reluctant to discuss the question of suicide with the client for fear that it may plant the idea in the individual's mind. This concern generally can be dismissed: most suicidal persons are relieved when the subject can be brought up directly and openly.

The discussion of suicide is often difficult for the counselor as it often evokes feelings of anxiousness and helplessness. The client, however, is often less anxious than the counselor. As a rule of thumb, you should always treat the discussion of suicide seriously — even if the client mentions it jokingly. If you are unsure of the client's suicidal tendencies you should immediately request consultation or supervision.*

Inquire about suicide:

- a. *Have you ever thought of harming yourself?*
- b. *Have you ever had thoughts of killing yourself?*
- c. *Have you feared that you might act on them?*
- d. *Are you having those fears now or recently?*
- e. *Is this a problem at this time?*

*For additional information on psychosis and suicide, see *Psychosis and Suicide* by Edward J. Lynn, M.D., available through the NDAC.

C. How does the client control strong feelings or impulses?

Rationale:

Impulse control is the individual's ability to avoid acting on strong thoughts or feelings. Not infrequently, the treatment experience will evoke strong feelings in the client that he may then act out in a nonproductive, and in some cases, destructive manner. Assessment of impulse control is of great prognostic importance in determining the individual's ability to continue treatment. The client with a history of poor impulse control may be likely to get angry and quit the program, or act out feelings irrationally in other destructive ways. On the other hand, clients with good impulse control and the patience to delay gratification are more likely to continue in treatment, to act in a more predictable manner.

The following items were developed to assess the individual's capacity for impulse control. An individual who displays a capacity for impulse control in one area can learn to utilize such control in other areas as well. For this reason, the questions tap a range of individual experiences in which impulse control and delayed gratification may be important.

Inquire about:

1. Impulse Control

- a. *Can you wait for something or do you have to have it now?*
- b. *Do you often act on the spur of the moment without considering the consequences? Give examples.*

2. Anger

- a. *Do you get angry easily?*
- b. *What kinds of things make you angry?*
- c. *How do you handle your anger?*
- d. *How would I know if you were angry with me?*
- e. *How do you handle frustration?*

3. Driving record

- a. *Do you drive?*
- b. *How often do you drive?*
- c. *What do you do when other drivers make you angry?*
- d. *How many times have you been stopped for a moving violation?*

4. Food

- a. *Have you ever been on a diet?*
- b. *Were you able to stick to it?*

5. Smoking

- a. *Do you smoke? (Did you smoke in the past?)*
- b. *How much do (did) you smoke?*

- c. *Have you ever tried to quit?*
- d. *What methods did you use?*
- e. *What were your reactions?*

6. Money

- a. *How do you handle money?*
- b. *Do you budget?*
- c. *Do you like to gamble?*

7. Savings

- a. *If you had a three-day supply of drugs, how long could you make it last?*
- b. *How do you plan ahead?*
- c. *When you want something badly, are you able to save up for it?*

D. Does the client have a potential for violence?

Rationale:

A client's potential for violence, if high, may impose severe limitations with respect to referrals and treatment management. That is, a client with a history of repeated violent outbursts may be a poor program risk. An individual may be violent in one of two ways. First, he may exhibit the impulsive violence that occurs when a person is angry or frustrated. This type of violence is the most unpredictable and can be disruptive to clinic functioning, to say the least. Assessment of this form of violence potential is interwoven with the assessment of impulse control. On the other hand, there are individuals who are violent but who have good impulse control. These individuals can plan criminal acts such as armed robbery or murder and successfully carry them out.

An immediate assessment of the potential for violence and the differentiation between the above two forms of violence is often difficult. You will probably want to begin with the client's history. This forms the rationale for the detailed questioning concerning the circumstances of violent behavior. Comprehensive assessment includes global evaluation of the individual's lifestyle, impulse control, and coping behaviors. Although arrest history cannot be simply equated with violence potential, it can provide you with some indicator of what to look for when exploring such potential. For example, the person who is apprehended for armed robbery probably has a higher potential for violence than one who is apprehended for simple possession of drugs. Also, individuals who commit crimes against persons probably have a higher violence potential than those who commit crimes against property (theft, bad checks, or victimless crimes such as prostitution and gambling).

Some individuals may become violent only when intoxicated or high. This is related to the poor judgment and diminished impulse control that may occur during intoxication, and, in general, is a better prognostic sign than the person who is impulsively violent while not under the influence of drugs.

Inquire about:

1. Violence potential

- a. *Have you ever harmed anyone? If yes, Who was it? What were the circumstances?*
- b. *Was it when you were drug free?*
- c. *Under the influence of drugs?*
- d. *Would you do it again under similar circumstances? Why or why not?*

2. Motivation

- a. *Was it survival or self-defense?*
- b. *Revenge? Note: Take into consideration data from arrest record if appropriate.*

OTHER PSYCHOLOGICAL CONSIDERATIONS

A final note about thought disorders, a type of psychosis. Thought disorders are clinically defined as a flow of thought that may become seemingly haphazard, purposeless, illogical, apparently confused, incorrect, abrupt, and bizarre. Thought disorders are most frequently found in schizophrenia and in persons having organic brain damage. Five of the basic categories of thought disorders are briefly described below:

1. Disturbances in *form* of thinking are all deviations from rational, logical, goal-directed thinking. This type of thinking fails to take the facts of reality into consideration. Hallucinations and delusions are the most common symptoms.
 - a. *Hallucination* is an apparent perception of an external object when no corresponding external object exists. It can be either auditory, visual, tactile (touch), olfactory (smell), or gustatory (taste).
 - b. *Delusion* is a false belief that arises without appropriate external stimulation and remains unshaken and fixed in the face of reason.
2. Disturbances in *stream* of thought are abnormalities in the manner and rate of the association made in thinking. Some of the most common symptoms are the following:
 - a. *Blocking* is a sudden stop in the flow of thought or speech in the middle of a sentence. The person is usually unable to continue the sentence, and when he tries a new idea crops up unconnected to the original thought.
 - b. *Intellectualization* is a state of brooding or anxious pondering about abstract, theoretical, or philosophical issues. The concepts are usually emotionally neutral.
 - c. *Tangential thinking* means that the goal of the thought is never reached.
 - d. *Perseveration* is the involuntary repetition of a specific goal or idea.
 - e. *Incoherence* is the result of disorderly thinking; i.e., thoughts do not follow in logical sequence so that verbalizations cannot be understood by the listener.
 - f. *Flight of ideas* is a nearly continuous, high speed flow of speech, jumping from one topic to another, with an illogical progression of thought. It is characteristic of manic states.

3. Disturbances in *content* of thought are characterized by the person's emphasizing that his thoughts are inexpressible.
4. Disturbances of *orientation* occur when the person is unable to recognize himself in his surroundings and to comprehend their relationship to time and space. Orientation to time, person, place, and situation is called *sensorium*. Other characteristics in this category include recent and remote memory, retention, and immediate recall. Impaired sensorium is found most commonly in organic brain disease or toxic psychosis.
5. Disturbances in *judgment* are similar in manifestation to poor impulse control and a fairly high potential for violence (discussed in previous sections). Judgment is the mental act of comparing or evaluating alternatives within the framework of a given set of values for the purpose of deciding on a course of action. The controlled postponement of action, then, is the essence of judgment. In the context of the mainstream of social values, most drug abusers can be said to have exercised *poor* judgment. In the clinical sense, a patient has a pathological disturbance of judgment when he continually and consistently avoids confronting reality by choosing alternatives he feels will be less painful. These alternatives may appear to him to be more immediately rewarding, but in the long run they may be counterproductive or even self-destructive.

OVERALL ASSESSMENT OF CLIENT'S BEHAVIOR

In summary, although confusion of thought in general, and thought disorders in particular, may indicate severe mental disturbances, care must be taken in assessing disorders of this type. Some of the symptoms described above can result from drug and alcohol abuse *per se* and some can be found in a patient who is intoxicated. Cultural and ethnic differences between the client and counselor must also be taken into account. The symptoms, then, may not be indicative of a serious underlying psychopathology.

In addition to the client's responses to questions, observation of his behavior during the interview situation provides important information. The Behavior Assessment Inventory that follows is designed to be completed *after* the assessment interviews. It is an example of one way to record observations quickly and concisely on a checklist. The main purpose of this inventory is to help identify clients who may show signs of psychological disturbance that may not be elicited through direct questioning. If all, or almost all of the answers are "NO," then further psychological evaluation may be indicated. Some treatment programs may wish to modify or adapt the inventory to suit their own special purposes.

BEHAVIORAL ASSESSMENT INVENTORY

To be completed by counselor after the assessment interview

Part I: Counselor Observation of the Client's Interview Behavior

- | | Yes | No | |
|--------------------------------------|--------------------------|--------------------------|---|
| 1. Behavior: | | | |
| | ☐ | ☐ | Is he friendly? |
| | ☐ | ☐ | Was he stoned, high, or intoxicated? |
| | ☐ | ☐ | Is he more unusual than most clients you have seen? |
| | ☐ | ☐ | Is he hyper? |
| | ☐ | ☐ | Is he inactive? |
| | ☐ | ☐ | Is he alert? |
| | ☐ | ☐ | Does he initiate conversation? |
| | ☐ | ☐ | Do you believe him? (Is he credible?) |
| | ☐ | ☐ | Is he nervous (visibly anxious)? |
| | ☐ | ☐ | Does he fidget? |
| | ☐ | ☐ | Does he sweat? |
| | ☐ | ☐ | Is he manipulative? |
| | ☐ | ☐ | Is he seductive? |
| | ☐ | ☐ | Does he direct the interview? |
| | ☐ | ☐ | Is he evasive? |
| | ☐ | ☐ | Is he suspicious? |
| | ☐ | ☐ | Is he cooperative? |
| 2. Thought Disorder: | | | |
| | ☐ | ☐ | Does he make sense? |
| | ☐ | ☐ | Is he thinking straight (or rationally)? |
| | ☐ | ☐ | Can you follow him? |
| | ☐ | ☐ | Does his attention wander? |
| | ☐ | ☐ | Does he answer questions appropriately? |
| | ☐ | ☐ | Is the client scared? |
| 3. Sensorium: Does the client know — | | | |
| | ☐ | ☐ | time? <i>year, month, day of month, day of week</i> |
| | ☐ | ☐ | place? <i>geographic location</i> |
| | ☐ | ☐ | person? <i>his own name</i> |
| | ☐ | ☐ | situation? <i>the interview or clinic</i> |
| | ☐ | ☐ | Is his memory okay? <i>recent, remote, recall</i> |

If all or almost all answers to the above are "No," then further psychological evaluation may be indicated.

Part II: Counselor's Impression of the Client

Yes	No	
___	___	Did you like the client?
___	___	Does he scare you?
___	___	Is he a "hustler?"
___	___	Is he a nice person?
___	___	Does he answer questions superficially or are his answers substantive? <i>Circle your impression.</i>

What can you expect of the client?

Other general impressions:

CONTENT AREA 4: RESOURCES

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CONTENT AREA 4: RESOURCES

Most clients enter treatment at a particularly low point in their lives. Often, it is because they have been arrested or because they are too sick, frightened, or tired to continue their drug-based life. It is not surprising, therefore, to discover that many clients' attitudes about themselves and their future prospects are quite poor at the beginning of treatment. They are frequently beset with feelings of failure, frustration, depression, or hopelessness. In this context, even seemingly neutral questions about such things as educational and vocational history or family issues may exacerbate these feelings, especially if the client has had problems in these areas as well.

Since the identification of client resources is vitally important in the development of an effective treatment plan, the counselor needs to inquire into these areas at the very outset of treatment. This section on client resources is therefore provided for use during the assessment interview. Specifically, it is important to know what the client likes to do, what he does well, what interests him, and what environmental factors exist that may help or hinder treatment.

For a treatment plan to be successful, it is necessary to help the client come to an understanding of his strengths and weaknesses and to assess the resources available to him in the community. A thorough assessment of the client's resources provides him with a better understanding of himself and of those things available to him; it also gives you vital information that can be incorporated into the treatment plan. Knowledge of the client's vocational and educational status as well as his environmental conditions, health status, and personal interests can all be a foundation from which a realistic and viable treatment plan can be developed.

Failure to adequately assess client resources could lead to unrealistic treatment planning or to the client's regression once treatment has been terminated. It is not enough merely to provide treatment; one must also establish some means for ensuring that the benefits of treatment are effectively utilized and maintained, whether through the provision of vocational or educational opportunities, or through the development of special interests or skills that give the client a sense of satisfaction with his life.

One way to offset the client's preoccupation with the negative aspects of his life is to focus equal attention on his strengths and resources. This is an effective way of communicating to the client that you are interested in him; it also helps the client think more positively about himself and the treatment that lies ahead. It is especially important that the client realize that the ultimate success or failure of treatment will depend, to a large extent, on the development and utilization of his strengths and resources as well as on the attitudes he brings to the program.

Finally, it is important to assess the client's need for supportive services to compensate for strengths and resources he does not possess. Many clients lack the educational or vocational qualifications necessary to obtain meaningful jobs. Others do not know how to manage their finances or seek financial assistance. Many experience great difficulties in the everyday necessities of living and suffer from poor housing, bad health, or inadequate nutrition. Still others may have difficulties establishing social relationships or utilizing their leisure time in meaningful or gratifying pursuits. Determining the client's shortcomings in these and similar areas is essential if he is to be taught the skills he needs to survive in ordinary society. The following areas of inquiry are provided to help you achieve that objective.

A. Is the client employed?

Rationale:

A client's employment status can affect the treatment program both directly and indirectly. The client who is unemployed or who lacks job prospects may feel that he has little or nothing to work toward in his life. In like manner, a client who expresses dissatisfaction with his work or who has shown an unstable job history may be an equally difficult case to work with. In such instances, his employment situation may even become a contributing factor in his drug abuse.

Because the client's future successes or failures rest so heavily on his ability to find a meaningful job when treatment is completed or to keep his present one, the assessment of the client's vocational resources is of the utmost importance. For clients with previous job experience, it may be relatively easy to make an assessment in this area. They can relate what type of work they like to do and what they have successfully done in the past. Most clients, however, should be helped to explore areas other than work to determine what they do well and what they enjoy.

Inquire about:

1. Nature of the current job (if employed)

- a. *What kind of work do you do?*
- b. *How long have you been there?*
- c. *Do you see yourself staying with this job?*
- d. *Do you like your co-workers?*
- e. *Do you see opportunity for advancement?*

2. Previous job history (if any)

- a. *What kind of work did you do before this?*
- b. *How long did you work at that job?*
- c. *Why did you leave?*
- d. *What did you like about the work there? Dislike?*

3. Nature of work while in jail, military, or similar situations (if appropriate). Ask questions similar to those in #2 above.

B. What kind of job skills does the client have?

Rationale:

Knowledge of the client's prevocational or avocational skills and work attitudes can also serve in the development of an effective treatment strategy. Additionally work traits (chronic tardiness and absenteeism, inability to get along with co-workers or superiors) give the counselor information that may indicate potential success or failure in treatment and be a guide for determining the type of treatment most likely to be effective.

Inquire about:

1. Previous training

- a. *What kind of training have you had?*
- b. *Where was training received? jail, military, vocational program, other*
- c. *What did you learn?*

2. Avocational skills and interests

- a. *When you were a kid, what kinds of things were you into?*
- b. *When you were a kid, did you have any hobbies? Do you have any now?*
- c. *What do you like to do?*
- d. *What kinds of things would you like to be able to do?*

3. Attitudes toward work

- a. *If you could write your own ticket, what kind of job would you like to have?*
- b. *What time of day do you work best?*
- c. *Whom do you know who has a good job? Why is it good?*

C. Does the client have job-related competencies?

Rationale:

In addition to the factors indicated above, an adequate assessment of other job-related competencies serves to pinpoint other areas that can be dealt with in treatment. It provides you with an indication of the client's ability to adapt successfully to his environment and to be resourceful in manipulating it. These strengths can be effectively incorporated into the client's treatment plan and utilized as a means of altering his current lifestyle and environment. Strengths that have been put to bad use in the past can often be put to good use with the proper treatment strategy.

Inquire about:

1. Hustling behavior

- a. *Before you came into treatment, how were you raising money for your drugs?* Straightforward and detailed probing may be required. If the client is evasive, focus on a particular day to serve as an example.
- b. *Where were you involved in the distribution system?*
- c. *What was your source of drugs?*

2. Implications of the client's status and income change as a result of entering treatment

- a. *How will your entering treatment affect your income or the way you earn a living?*
- b. *Will entering treatment affect your status in any other way?*

D. How does the client spend his leisure time, relax, have fun?

Rationale:

Although the pursuit of recreational and social activities is not as important as the location of jobs, the ability to utilize leisure time in an enjoyable and productive manner may be of considerable importance in helping clients achieve a sense of well-being. As in the assessment of vocational resources, it is important here to focus on what clients like to do and what they are able to do well. It is also valuable to find out what the client does during leisure time, with the hope of exposing him to new alternatives. Clients who enjoy physical activities for example, may not be aware of the facilities available; others might find enjoyment in participating in drama or other creative activities. The important point is that most clients will not know about activities or facilities that are available to them. Consequently, the determination of their interests in the light of these resources is an important part of the assessment process.

In addition to discussing the client's pastimes, it is important to know where he spends his time and with whom. Does he feel comfortable with individuals who don't use drugs or does he spend most of his time in places frequented primarily by drug abusing individuals?

Inquire about:

1. Current activities

- a. *Other than drugs, what do you do with your free time?*
- b. *Given that you won't have much money, how would you like to spend your time enjoying yourself?*
- c. *Do you know how you might go about pursuing these interests?*
- d. *Do you know of any places that you might pursue these interests?*

2. Relationships with non-drug-abusing individuals

- a. *How do you feel about straight people? (people who do not abuse drugs)*
- b. *Is it difficult for you to talk with these people?*
- c. *Do you have many straight friends?*
- d. *Do you know any places where straight people hang out?*
- e. *Do you ever go there? If yes, How do you feel about going there?*

E. Where does the client live? With whom?

Rationale:

Finding and maintaining a decent place to live is essential for survival. Inadequate living conditions can not only lead to health and safety problems, but also result in the deterioration of morale, family relationships, and achievement motivation. Hassles with landlords or other tenants can aggravate the problem and result in conditions of anxiety or unpleasantness for the client. Such conditions can seriously impede the client's progress in treatment and, therefore, must be identified if they are to be dealt with in the treatment program.

Inquire about:

1. Duration of current residence
 - a. *Where do you live?*
 - b. *With whom do you live?*
 - c. *How long have you lived there?*
2. Risks involving current housing
 - a. *Does your spouse or roommate use drugs?*
 - b. *If yes, How do they feel about your trying to kick?*
 - c. *What things at home make it hard or easy for you to kick?*
3. Satisfaction with or plans to change current housing
 - a. *What do you like about your present living conditions? Dislike?*
 - b. *Is it dangerous staying where you are presently living? In what way?*
 - c. *What is preventing you from making a change?*
4. Previous residences
 - a. *Where did you live before this?*
 - b. *How long did you live there?*
 - c. *What has been the longest period of time you lived in any one place?*
 - d. *Do you move about often to get away from people or problems?*

F. How far has the client gone in school?

Rationale:

The assessment of a client's educational background is necessary to determine additional educational needs and also to acquire information that could be useful in treatment planning. Many clients lack basic literacy skills and cannot make much progress after treatment unless these deficiencies are remedied. Since the client's vocational opportunities will be dependent to a large extent upon the kinds and amount of education received, adequate assessment in this area is essential.

A client's educational background also serves as an indicator of overall motivation and achievement. His attitudes and feelings regarding school and learning may greatly influence his attitudes toward authority figures in general and specifically toward members of the treatment staff. The client's success or failure in school may indicate his potential for success or failure in the treatment program. The client who has done well in school is apt to be a better candidate for treatment because of his greater stamina and motivation alone, if not because of healthier attitudes in general. Conversely, the client who has done poorly in school often exhibits considerable lack of motivation and is likely to assume a more negative attitude toward the program. That plus the fact that he may have fewer recognized skills and credentials make this type of client a high failure risk.

More positively, the assessment of a client's educational background gives a good indication of personal interests and attitudes. Even those clients who evidence a strong dislike for school usually have one subject or course that appeals to them. Also, many clients, including those expressing a strong dislike for formal schooling, may undertake activities of a self-educational nature. They may spend a great deal of time reading or may take special interest courses. Knowing these things helps you focus on positive aspects of the client's existence that can be incorporated into the treatment program or, at the very least, be further encouraged in an effort to help the client devote more of his time and energies to constructive activities.

Inquire about:

1. Degrees and certificates

Do you have any diplomas, degrees, or certificates from school or any other training?

2. Academic performance

- a. *What were your grades like?*
- b. *How did they compare with other students' grades?*
- c. *How were they with respect to where you wanted to be?*
- d. *Could you have done better if you wanted to?*

3. Attitudes

- a. *What were your feelings about school?*
- b. *What were some of the things you liked about school? Disliked?*

4. Special interests

- a. *Were there any subjects that you really liked?*
- b. *Were there any subjects in which you got good grades?*
- c. *Were there any teachers who really turned you on or encouraged you?*

5. Interest in continuing education

- a. *Have you ever thought of finishing high school (college) or getting your GED (degree)?*
- b. *How important do you feel education is to you?*
- c. *How do you feel about the educational system in general?*

6. Self-education

- a. *Do you ever read books or magazines?*
- b. *If yes, Tell me about something you've read recently or the kinds of things you'd like to read if you had the chance.*
- c. *Do you take any special interest courses? e.g., adult education courses, community sports or crafts courses, computer, secretarial, etc.*

G. Does the client have any medical, dental, hygienic, or nutritional problems that require attention?

Rationale:

In addition to problems associated with their use of drugs, many clients will have medical and dental problems that demand immediate attention. The client who is suffering from poor health or poor nutrition will ordinarily experience greater difficulty carrying out the requirements of the treatment program. Such clients are often considerably lacking in motivation and stamina, factors that can not only influence progress in treatment but also affect other segments of life, especially the ability to keep a job. At the very least then, the assessment process should include a determination of any health problems that may require immediate care. Where medical care is indicated, the client should be referred. Beyond that, the assessment should focus on the client's knowledge of proper health care practices, including nutrition and personal hygiene.

With female clients, it will be necessary to inquire about gynecological problems. Questions pertaining to contraceptive practices, gynecological care, pregnancies, abortions, and menstrual health should be included.

Inquire about:

1. Medical or dental problems

Do you have any medical or dental problems that need immediate attention?

2. Nutrition

- a. *How many meals do you usually eat each day?*
- b. *Do you eat breakfast? If applicable, Do your children have breakfast before going to school?*
- c. *What do your children do about lunch at school (buy, take)? Do they have breakfast and lunch every day?*
- d. *What kinds of foods do you generally eat for your main meals?*
- e. *Do you feel that you and children, if applicable are getting enough to eat?*
- f. *Do you receive any food assistance benefits? e.g., surplus commodities, food stamps, donated foods, free school lunches*

3. Children's health (if applicable)

- a. *Are your children in good health?*
- b. *Who is responsible for their medical care? Specify clinic or private physician.*
- c. *What vaccinations have they received? When?*
- d. *Any serious illnesses or hospitalizations ever for any of the children?*
- e. *Are you concerned about any unusual behavior in your children? bed-wetting, nightmares, hyperactivity, etc.*
- f. *Do you ever give drugs to any of your children for special problems such as sleeplessness, nervousness, or hyperactivity?*
- g. *Where do you keep your methadone or other drugs in the house? Are they in a child-proof place?*

Except for question 4.e. (which also applies to men), the following sections contain questions pertaining to female clients. You are not trying to take a gynecological history here, but simply trying to assess whether or not a medical referral or some basic education is needed.

4. Contraception and gynecological care: knowledge of available techniques — oral contraception, foam, IUD, rhythm method, sterilization of self or spouse

- a. *What kind of birth control do you use, if any?*
- b. *Who takes responsibility for contraception?*
- c. *When was your last Pap smear? Pelvic examination? What were the results?*
- d. *Have you ever been treated for pelvic infection? If yes, Which?*
- e. *Other physical-sexual problems? Specify: venereal diseases, trichomoniasis, fungus infection, urinary problems, painful intercourse, unusual discharge.*

5. Pregnancies and abortions

- a. *How many pregnancies have you had? Were there any miscarriages or delivery problems? Caesarean, etc.*
- b. *Have you ever had any abortions? What kind? Did you have any medical after-effects?*
- c. *What were your feelings about having the abortion? if applicable*
- d. *Are you pregnant now? If yes, Are you receiving proper medical care? From whom or where? If not under physician's care, make plans for immediate referral.*

6. Menstrual health

- a. *Do you have regular menstrual periods?*
- b. *Are periods different when you are on or off various drugs?*
- c. *Do you experience any difficulties (pain, excessive bleeding) with your periods? Is there a difference when you are on or off drugs?*

H. Does the client have a regular source of income?

Rationale:

A client's financial status — income and ability to manage money — can greatly influence his progress. An inadequate income or poor financial management can exert tremendous physical and psychological pressures on the client. The client with a steady and adequate source of income will be able to provide for his family and meet debt obligations. Many clients, however, will not have a steady income and may even depend on welfare or other forms of social assistance for survival. There are still others who may have an adequate income but who have incurred heavy financial obligations either from too much credit buying or from mismanagement of their financial resources (gambling, inability to save, impulsive spending).

The lighter the client's financial load, the easier it will be for him to progress in treatment. Heavy financial burdens can not only hinder treatment but can even contribute to the client's drug abuse. Since financial hardships tend to go hand-in-hand with poor living conditions, poor health, unemployment, and negative feelings (hopelessness, anxiety, and despair), it is extremely important that an assessment be made of the client's financial status and practices. In some cases, you may have to work collaboratively with social service agencies or other third party reimbursers.

Inquire about:

1. Source of income (if not covered in employment section)

2. Sufficiency of income

Is your income sufficient to meet your living needs?

3. Money management

a. *Do you have any money in reserve?*

b. *Can you hold onto money when you get it or do you spend it right away?*

c. *Do you have a bank account?*

d. *Where does most of your money go?*

e. *Do you like to gamble or play the numbers?*

f. *Where do you get your checks cashed?*

4. Credit purchases (focus on whether the client loses money because of poor consumer practices)

Do you tend to pay for things right away, or do you take time payments?

5. Debt management (the extent of indebtedness and the client's credit rating)

a. *How do you handle your debts and bills?*

b. *What do you think your credit rating is like?*

6. Bonding for security jobs

a. *Do you have any interest in security jobs that would require bonding?*

b. *Do you think you would have any difficulty getting bonded for security jobs?*

I. What is the client's means of transportation?

Rationale:

Transportation is an often overlooked area, but it is very important if a client is expected to make his way successfully in the world. The focus here is on the client's ability to move about freely in his environment. Does he have a driver's license? Car? Does he know how to get around by bus or train? Is he afraid to move out of an accustomed neighborhood to an unfamiliar or hostile part of town? Many clients with problems are hesitant to bring them up, or have become hopelessly resigned to their situation. Consequently, it is well worthwhile to ask the few questions required to ascertain problems or shortcomings in this area.

Inquire about:

1. Means of transportation (own transportation, reliance on others, use of public transportation)
2. Possession of driver's license; availability of car
3. Knowledge of mass transit system
4. Anxiety related to mass transit
5. Distances involved: distances client lives from work, stores, treatment center, etc.

J. Does client have current or pending legal problem (criminal or civil)?

Rationale:

While most programs ask detailed questions about a client's arrests and convictions, it is equally important to know whether they are involved in *other* legal disputes that might require seeking legal aid. Although many clients have had frequent contacts with the law, most do not fully know their rights or where to go for legal help. This is especially true with regard to legal issues unrelated to criminal activity. Relatively few clients, for example, will know how to handle divorce proceedings or other civil litigations. For these reasons, it is important to pinpoint problems in these areas.

Inquire about:

1. Current arrests, suits, or other pending litigations
2. Divorce or alimony problems
3. Tenant or consumer difficulties

K. Does the client have relationships with other agencies?

Rationale:

Many drug abuse clients have come into contact with various social agencies either through financial necessity or in their search for drug treatment or related services. In fact, clients are often introduced to the treatment program through referrals from other agencies. Since many of the agencies provide valuable supportive services, it is essential that an assessment be made to determine which services should be incorporated into the treatment plan. If clients do not have contacts with other agencies, it may be necessary to initiate such contacts depending upon the client's unique set of problems.

Inquire about:

1. Assistance from other social service agencies (current or past)

Have you ever received assistance from—

- a. *welfare agencies AFDC, food stamps, etc.;*
- b. *Vocational Rehabilitation;*
- c. *Employment Security Commission;*
- d. *Veterans Administration hospital or outpatient service;*
- e. *community health services dental clinics, free health clinics, etc.*

- f. *probate court*;
- g. *insurance policies* for medical, psychological, dental;
- h. *other services*?

2. Eligibility for assistance:

Do you know if you are eligible for assistance from any third party payors such as the above?*

*This may need rephrasing in terms the client can understand.

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INTERVIEWING SKILLS

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INTERVIEWING SKILLS

Most people have been interviewed at some time in their lives. In fact, the term is so broadly used that it conjures up many images — social work interviews, talk show interviews, and market research or public-opinion survey interviews. In this course, however, the term will be used to refer to a very specific type of communication and interaction.

Effective interviewing, especially in situations involving clients seeking professional assistance, requires that the interviewer have specific skills and that he use certain techniques. The purpose of this section, therefore, is to provide basic definitions and guidelines to help you acquire the skills needed to shape the interview situation so that it will meet both client needs and program objectives.

THE NATURE OF THE INTERVIEW

The interview is a *verbal interchange with a specific purpose or goal* that usually has some overall structure or format. The typical interview is face-to-face (as opposed to over-the-phone), and involves spoken (not written) communication between counselor and client. Although most interviewing takes place in the office of an agency, it can also be conducted in a more informal setting such as a neighborhood recreation center or the client's home, if necessary.

The type of interview discussed here is used to complete the Assessment Interviewing Guide (AIG). The AIG forms the core of effective treatment planning. This type of interview involves three subobjectives:*

1. *Information Gathering:* The AIG provides a framework for the collection of past and current information about the client. This information, in turn, provides knowledge that will be helpful in understanding the client's feelings, attitudes, and situation. Such understanding is a prerequisite for effectively assisting the client.
2. *Diagnosis and Assessment:* An appraisal of the client is necessary to determine which service components will be most helpful in the treatment process. The information you gather is incorporated into this appraisal, which is made in conjunction with the treatment planning board. The assessment objective involves a decision-making process that must, of necessity, include the client. Some of the essential questions that must be asked include:
 - a. What will be the best treatment modality for this client?
 - b. What are the most critical elements of the treatment plan?
 - c. Are there things that must be dealt with first (such as medical treatment)?
 - d. What is the client's state of readiness for treatment? His state of rationality?
 - e. What are the major obstacles that the program must overcome or contend with to provide effective treatment?
 - f. What are the most important resources that are available to the counselor in terms of the client's strengths and environmental factors?

*Adapted from: Kadushin, Alfred. *The Social Work Interview*. New York: Columbia University Press, 1972.

3. **Counseling:** Your primary objectives in the interview are information gathering and assessment. But, you will also be discussing many areas that are directly related to the change process that is implied by the client's presence in the treatment program. More importantly, however, your interaction is setting the stage for your relationship with the client. You are beginning to establish trust and rapport. Since it is quite likely that the client will explore and discuss his feelings and problems and perhaps achieve a greater understanding of them, this will be an important dynamic not only during the interview, but also in further encounters that are of a therapeutic nature.

In addition to having a specific goal or set of objectives, an interview usually possesses some sort of structure. The structure that you impose on both the content and the process of the interview facilitates achieving your purpose. The AIG provides some of the content structure for the interview in each of the "4 Rs" sections. Further structure is incorporated into the interview process through the skills and techniques employed, including the kinds of questions asked and the kinds of responses made during the interview.

In summary, an interview is a unique communication process. It is unlike day-to-day conversation because it has a specific purpose and structure, and because one person is clearly directing the interaction toward that purpose. It relies on an information-gathering strategy in which the interviewer utilizes certain types of questions and responses. Although the agenda is designed to accomplish the interview's purpose, it must be remembered that the ultimate purpose is to serve the needs and best interests of the client.

Interviewing should also be distinguished from counseling. The interview is an interaction that uses some counseling techniques and that requires rapport and trust between the interviewer and the client. However, while the counseling process is aimed at facilitating the achievement of specific change to alleviate problems, the interview is not. The interview is aimed at gathering specific information for use in assessing the client. In this case, the outcome of the interview process will be a treatment plan upon which the counseling process will be built.

TYPES OF INTERVIEWS

There are numerous types of interviews and interviewing techniques, ranging from ones of a highly structured nature to those requiring little or no structure. The degree of structure and the techniques employed in the interview will generally be determined by the type of information being sought. In general, though, we can distinguish three major types of interviews: *the standardized interview*, *the unstandardized interview*, and *the focused interview*.

The *standardized interview* is one in which the interviewer is given a list of questions and told to ask them exactly as they are worded and in exactly the order in which they appear. You may not add or delete any questions. This type of interview is generally utilized in situations where specific kinds of information (especially factual) are desired, and is the kind generally employed in market research and public opinion polling where large samples are required.

The *unstandardized interview* is one that has a general purpose but is totally flexible in terms of how the information is gathered. This type of interview is sometimes referred to as in-depth interviewing and is commonly utilized in situations where information concerning a client's feelings, personal history and/or personal problems is desired. It is also often used in exploratory situations as a means of pinpointing informational areas that may need to be tapped later in a more formal or structured interview situation.

This course will be concerned with the *focused interview*, which draws its format from both of the above interview types. The focused interview attempts to compensate for the weaknesses inherent in each of the other two approaches while building on their strengths. A guide containing objectives and suggested questions is given in the focused interview situation but the interviewer retains considerable freedom in the formulation, rewording, and ordering of questions. This permits him to adjust for differences in client reactions and to follow the natural flow of the interaction within a given interview situation.

THE INTERVIEW PROCESS

All interviews must proceed through certain basic stages regardless of the particular structure involved. These stages consist of the introduction, the development stage, and the final or termination stage of the interview.

The *introductory stage* includes activities that serve as preparation for the interview. Such activities extend from a preparation of the physical environment to clarification of roles and expectations with respect to the client. In this stage the purpose of the interview is defined, and the general tone is set for the remainder of the interview and for subsequent interviews as well.

The second stage is referred to as the *development stage*. It constitutes the main body of the interview. The concern here is with the facilitation and achievement of the objective of the interview. Activities involved in this stage include observation, listening, asking questions, responding to the client, showing understanding, and essentially maintaining the communication flow. Even if the interview continues over a series of meetings, the development stage is still in progress, although temporary closure is achieved after each meeting.

The final stage of the interview process is the *termination stage*, which marks the completion of the interview. This final stage begins once the purpose of the interview has been accomplished. Activities in this stage include a summary of the interview at its conclusion, a recording of the information acquired, and an analysis of the interview. Each of these three stages is discussed in greater detail in the following pages.

Introducing the Interview

The initiation of the interview sets the tone for the entire interaction. If this phase is handled well, it is more likely that the interview will be smooth and productive. Before the interview begins, certain things must be considered. First, it is necessary to anticipate agendas. Both the client and you may have thoughts and feelings about the interaction. Your program may have a reputation in the community, or the client may have been in a program before. Some clients may be "checking out" the program, others may be there because of pressures from the family or from the court system. It is desirable to consider all these possibilities as well as to identify anything going on in you that might interfere with the interview situation.

Other activities that should be undertaken before the onset of the interview include:

- A review of that portion of the AIG that will be covered
- A review of any background data available on the client
- The preparation of the physical environment with attention paid to space, lighting, ventilation, etc.

(Avoid such distractions as ringing telephones and frequent interruptions. Check on coffee, ashtrays, and similar items that might add to the client's comfort.)

After the necessary preparations have been made, the next step is to greet and introduce the client. The tone of the interview is set at this time. It is desirable to have some *brief* general conversation at the beginning of the interaction to ease the transition from an everyday social relationship to an interview relationship. Keep open the possibility that a long wait, a difficult child, or other problems coming up prior to the interview may be affecting the client. Do and say things that enhance the client's comfort and that also signal the beginning of the interview.

Once the general greetings and introductions are completed, you are then ready to introduce the client to the interview situation *per se*. Activities involved in this stage of the interview process include:

- *Role clarification.* Examine both positive and negative aspects of your role situation. The client himself may provide clues that will help you better define your role with respect to that client. You may need to separate yourself from the criminal justice system, the welfare system, or other persons or institutions the client may perceive you as representing.
- *Statement of purpose.* State the purpose of the interview so that the client sees the benefit of cooperating in the process and so that his role in the interview situation is clarified.
- *Setting expectations.* It may be tempting not to minimize expectations, especially if you want to get maximum cooperation from the client. However, not establishing limits often results in the client's feeling frustrated and feeling that he has been misled. Promote realistic expectations about the interview process and its outcome, especially in terms of what can or will be done for the client, and what the program expects the client to do for himself.
- *Listening and observing.* Take your cues from a client's verbal and nonverbal behavior to determine when an issue is understood or when further clarification is needed.
- *Discussion of confidentiality.* During the interview, you will be asking the client to disclose personal information. In order to build trust and ensure maximum cooperation on the part of the client, you may need to raise the issue of confidentiality. Be honest about what kinds of information you are able to hold in confidence, and do not reassure falsely. Since you are also describing the purpose of the assessment interview during the introduction, the client may need to be made aware that other program staff involved in the treatment planning process may have access to information gathered during the interview. Your discussion should be consistent with your program's policies regarding confidentiality; in some instances, confidentiality will have been explained to the client during intake. In short, the topic of confidentiality should be mentioned, but should not be an elaborate or extensive discussion.

If notes are taken or tape recorders used during the interview, it is especially important that you explain the purpose of and get the client's permission to use such procedures to allay any fears regarding possible breach of confidence.

Although the preceding list may seem lengthy, the actual introduction stage should be brief. A common mistake is spending too much time on the negotiation of rules and activities. It is true that the client may have had a series of bad experiences with interviewing and information-gathering situations, but this does not mean that you should apologize for the interview. This may be the first time anyone has taken a genuine interest in the client as a person who has something important to share. The extent of your interview, the manner in which you present it, and the emphasis you place on its role in the treatment process should communicate a message to your client that makes him say to himself: *Not only is this interview important, but also this is a competent and caring individual with whom I am talking.*

Developing the Interview

Phrasing Questions and Responses

The guidelines in this section are intended to increase the accuracy, scope, and relevance of the information obtained during the interview. An understanding of the basic techniques presented here will help you get what you need from the interview. It has been said that if you talk for more than one-third of the total interview time you are saying too much. Therefore, the structure and guidance that you provide when you speak needs to be clear and skillful.

Your questions and responses should always be connected to the purpose of the interview and, in this case, be directed toward the section of the AIG that you are exploring. At the same time, it is necessary to maintain an atmosphere conducive to trust and rapport; this is accomplished by listening, showing interest and understanding, and by providing background information when necessary. Adhering to these principles helps reduce the error or bias found in every interviewing situation.

As a further precaution, it may be helpful to consider the following three factors each time you speak (Kahn and Cannell).

- **Acceptance.** This pertains to the interviewer-client relationship. It does not mean that you should "agree" with the client but, rather, that you should try to sustain a non-judgmental attitude with respect to the client.
- **Bias.** It is important that information gathered be accurate. Therefore, questions and responses should be phrased so that you help the client provide information that reflects an honest description of his feelings or situation. You should avoid leading questions or statements that might cause the client to give responses biased toward what he thinks you want him to say. Also, be aware of the internal consistency of what the client is saying. If at one point he describes positive feelings about a subject, but later describes negative feelings or experiences about the same subject, you may want to explore this area further.

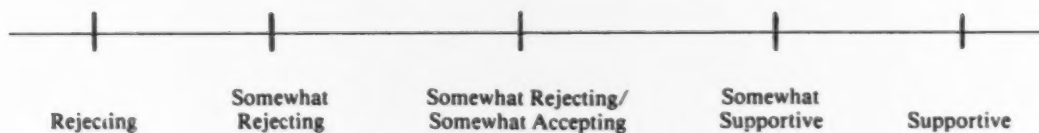
- **Relevance.** Questions and responses should be directed toward the disclosure of information relevant to the desired objective (i.e., the portion of the AIG being discussed or information essential to the treatment planning process). Interaction regarding information of a nonessential or unrelated nature should be kept to a minimum.

The three scales below are a graphic representation of the degrees of acceptance, bias, and relevance. The scales are part of the Process Observation Feedback Forms used during the training sessions in the interview simulations to give feedback to the interviewer. Used this way, the process observers rate the interview as a whole.

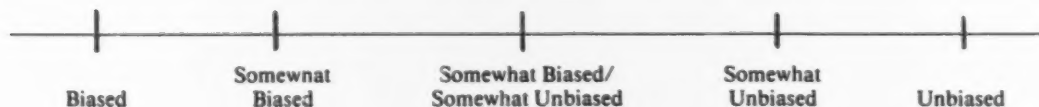
Relating the scales to actual interviews points out the fact that it is not always desirable to rate high on all the scales. For example, a client who jumps from subject to subject while answering a question may be appropriately focused on the main subject with a question that rates high on the relevance scale but low on the acceptance scale. On the other hand, a client discussing an area that is important but very painful may be more appropriately guided with a response that rates high on the acceptance.

Interviewer Rating Scale

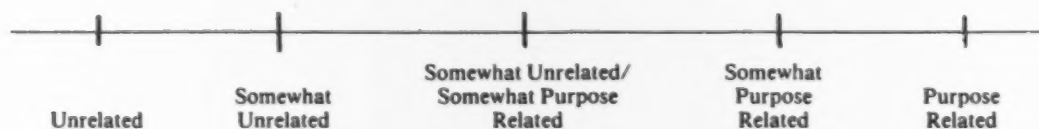
Acceptance



Bias



Relevance



Guidelines for Questions

In addition to the overall factors mentioned previously, there are a number of specific guidelines that should be followed in formulating interview questions. These guidelines are listed below along with specific examples for each case.

- **Ask only one question at a time.**

Ask: *When did you start using drugs?* (Wait for answer and then ask next question.)

Not: *When did you start using drugs and how has your life been different since you started?*

- **Keep questions simple.** Use understandable language and avoid words that have double meanings.

Ask: *How did you get interested in playing in a band after working hours?*

Not: *What kinds of stimuli led you to get involved in such a far out place in regards to your present avocational pursuits?*

- **Keep questions brief.** The general rule is that a question should be no longer than two sentences. If the question is longer, the client will most likely find it difficult to remember the entire question, or will only answer part of it. Your first sentence may do one or all of the following: set the context for the second question, provide a rationale for it, prepare or motivate the client to respond to it.

First: *Earlier, you said it's important that you not repeat some of the negative experiences you had when you entered other treatment programs.*

Second: *What kinds of negative experiences were you referring to?*

- **Be specific.** State the time, place or context you want the client to consider.

Ask: *How would you describe your life when you were still in high school and living with your grandmother?*

Not: *How would you describe your younger years?*

- **Ask questions in terms of client's immediate experience** rather than in terms of generalities.

Ask: *How much dope did you smoke the last time you got stoned?*

Not: *How much dope do you usually smoke?*

- **If the question asks for criticism, give the client an opportunity to voice the positive aspects** before asking for the negative ones.

Ask: *What are the good aspects of your relationship with your husband?* (Wait for answer and then ask about negative aspects.)

Not: *What bothers you about your relationship with your husband?*

- **Ask what or how instead of why** questions to avoid "because" responses and responses of a vague and all-explanatory nature.

Ask: *What are some of the things that cause you to keep taking dope?*

Not: *Why do you keep taking dope?*

- **Ask questions that keep bias or built-in answers to a minimum.**

Ask: *How would you describe your feelings about yourself over this past year?*

Not: *You really have been doing some pretty self-destructive things this past year, haven't you?*

- **Avoid questions that elicit a simple yes or no answer.**

Ask: *In what way do you feel that this treatment program will be of help to you?*

Not: *Do you think that this treatment program will be of help to you?*

At first you may experience difficulty in keeping all these guidelines in mind during an interview, but you will find that the more you use them, the smoother and more efficient the interview becomes. In the beginning it may be desirable to draw up questions in advance and to check them out in terms of the above guidelines. After a while, however, using the guidelines will become an automatic part of the question-formulating process; constant checking will no longer be necessary.

Types of Questions

The types of questions that you use will determine to a very large extent the types of responses that a client is willing or able to give. There are times when only one type of question may be called for in an interviewing situation and other times when a combination of several types may be needed.

Most questions can be classified as either closed or open-ended in nature. A closed question involves *multiple choice, yes or no, agree or disagree* answers. The advantage of using a closed question is that it forces a simple, clear answer; unfortunately, it also prohibits or limits useful collaboration. An additional danger of asking questions of this type is that a valid response category (*maybe, sometimes*) may be omitted.

Open-ended questions involve *essay or discussion* responses; there is little or no guidance with respect to the form or content of the answer. Generally, open-ended questions are preferred because they promote better rapport, are less leading, and elicit more information. Their drawback lies in their potential for generating irrelevant or tangential information.

There are some questions that are technically closed in that they call for a simple response but suggest the need for elaboration, for example, *Are there other feelings you had?* An alternative, more open question would be, *What other feelings did you have?* There is also another technique that is frequently utilized called the "funnel approach" in which both open-ended and closed-ended questions are presented.

In many interview situations, you may need to obtain information of a sensitive nature. In such instances, it is often better to use indirect or projective methods of questioning. In this approach, questions are asked about someone other than the client or about hypothetical situations: the assumption is that the client will describe his own feelings and reactions in the place of another person. A disadvantage of this type of questioning lies in the interpretations of the response. A considerable amount of skill is needed to interpret responses properly. If a projective question is used, then it is often helpful to follow such a question with a direct question on the same issue, for example, *How do you think a person would feel . . . ? How would you feel . . . ?*

In some instances, silence on the part of the interviewer would indicate to the client that more information is expected. Care should be exercised in using this approach, however, because silence can also communicate nonacceptance or disbelief. A variation on the silent question technique is the use of the "uh-huh" or "mmm" response, which serve to provide encouragement and support further communication.

Finally, there are questions that are referred to as "probing": they push for additional information. These questions are best utilized when the client's responses are confusing or inadequate, and further classification is needed. Typical examples of this type of questioning include: *Tell me more about that*, or *Anything else?* or *Can you give me a specific example?* Care should be taken when utilizing this approach, however, not to probe so deeply that the client becomes defensive and retreats from the communication process.

Guidelines for Responses

Your success in extracting information during the interview process depends not only on your ability to formulate questions well but also on the nature of your responses (statements that show that the client is being heard and understood).

Responses may be used to preface a question and to set the tone of the subsequent communication. They are also effective in generating information.

In addition, your responses contribute to building rapport and trust because they show the client that you understand. Care must be taken, however, not to put words in the client's mouth for the purpose of demonstrating your insight. Remember that the purpose of the interview is to gather information from the client's own point of view. If responses are skillfully presented, the client will probably feel encouraged to elaborate the subject being probed.

A response may restate, reflect, or summarize what the client has presented in one of three ways. It may deal with content only, with feeling only, or with a combination of both. The following example illustrates the differences in responses based on this approach.

Client: *My foreman's always on my back at work. If this keeps up, I don't know if I'm going to quit or not. I know I shouldn't but I get so fed up I just want to walk out sometimes.*

Interviewer: *So you're having a really tough time at work.* Content only

— or —

Sounds like you're pretty fed up — kind of angry. Feeling only

— or —

You seem so fed up with your foreman that you're having trouble deciding if you should stay with the job. Feeling and content

The form of the response will depend upon the extent and nature of the information desired. The technique for making responses is based on the same three guidelines discussed previously: acceptance, bias, and relevance. An additional guideline that is frequently employed involves the rephrasing of the client's words in cases where a topic has been discussed earlier in the interview and comes up again, for example, *If I remember correctly, you said earlier that . . .*

Some of the pitfalls that lead to noneffective responses and that impede the interview's progress toward the goal are noted below. In examining each of the examples, refer back to the scales described for acceptance, bias, and relevance.

- Judging, moralizing
(Low on acceptance
scale) *You know you really
should stay there. A
job is pretty important.*
- Denying feelings,
arguing, lecturing
(Low on acceptance
and bias scale) *Oh, everybody gets fed
up once in a while —
you're not that bad off.*
- Playing psychoanalyst,
over-interpreting
(Low on bias scale). *I'm wondering if you have
trouble with other authority
figures.*
- Digressing, story-
telling (Low on
relevance scale) *I worked for a guy like
that once too; didn't know
what to do until I found
out . . . and . . .*

The Interviewer — A Closer Look

It is impossible to discuss the interview process without commenting on the interviewer. Thoughts, feelings, behaviors, and attitudes that surface during the interview affect both interviewer and client alike. These factors influence all aspects of the interview situation: expectations, questions, responses, and even body posture. They can also bias impressions and conclusions about what is heard and observed. The diagram on the following page depicts the major factors that combine to produce bias in the interview (Kahn and Cannell).

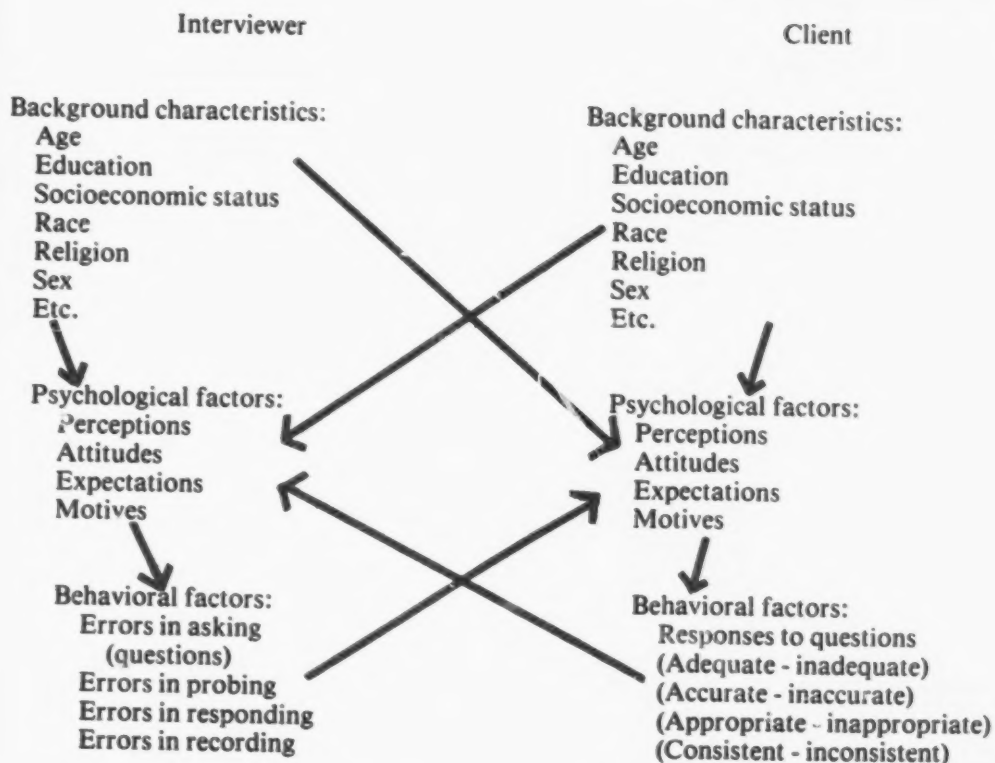
The background, perceptions, and behaviors of one party greatly influence the other. If, for example, you suggest in some small way that you are not interested in or unable to understand or accept what the client is saying, information may be withheld. Conversely, if you expect the client to respond in a certain way, you are likely to overlook some of the information the client is sending. In such situations, inaccurate or incomplete information may be obtained.

Both you and the client bring your backgrounds and experiences to the interview. Obviously, these characteristics form the basis for various impressions, but you should be open to learning about the client through the interview process — not through stereotypes and attitudes formed prior to the interaction. The key to being able to do this is to recognize and understand the feelings, attitudes and behaviors that are likely to be aroused.

When an interviewer first learns that he should be nonjudgmental, should not become angry, should not become dependent upon the interviewee's affection and response, he tries to suppress his feelings, and as a result he tends to become artificial and stilted in his responses. It would be better to recognize the existence of such feelings and to learn to control their expression, for these feelings are not unnatural but merely inappropriate in the professional situation. If an interviewer is aware that he is becoming angry, he is then in a position to regulate his feelings better than if he denies to himself that he has such feelings. Control of feelings rather than absence of feelings on the part of the worker is the goal.*

Think of the "difficult" clients that you have known or heard described. They are often assigned labels such as hostile, seductive, crazy, con-artist. Using these labels, interviewers often speculate about approaches that make their feelings and attitudes manageable. Your success in working with clients in the interview will depend not only on your interviewing skills *per se*, but also upon your ability to recognize and deal with your own feelings and attitudes.

MAJOR FACTORS INFLUENCING THE INTERVIEW PROCESS



*Garrette, A. *Interviewing: Its Principles and Methods*. New York: Family Service Association of America, 1942, p. 22.

Terminating the Interview

The assessment interview process may be completed in a series of interviews or all in one sitting. If the process is conducted using several interview sessions, then the components involved in terminating the interview should occur at the end of *each* session. If the assessment interview is completed in one long session, then you will only go through the termination process once. (It is important to point out that "termination" is often associated with the end of the treatment process. This is not the meaning being discussed in this portion of the unit on interviewing skills.)

Your interaction with the client at the termination point(s) should include:

- A summary of what has occurred and been accomplished during the interview
- A discussion of the expectations each of you has for the future, for example, *Where do we go from here?*
(This is an extremely important step when the AIG has been completed and you are explaining the next phase of the client's treatment process, for example, contracting for and implementing a treatment plan.)
- A clear statement that indicates that the interview is about to end and that offers the client the opportunity to tie up any loose ends or add a comment

When actual interaction with the client is completed, you should record your data and analyze both your personal reactions to the interview and your impressions of the information gathered. This will help you prepare the case history summary and develop the treatment plan. Moreover, a conscious effort to review the process will contribute to your effectiveness in future interviews.

The following is a list of questions that may be helpful to you in analyzing your reactions.

- To what extent were the purposes of this interview achieved?
- What interventions helped to achieve the purposes? What intervention(s) hindered the achievement?
- What was your feeling about the client?
- At what point was your feeling most positive? Most negative?
- How might these feelings have been expressed in what you as interviewer said or did?
- If you now empathize with the client, how did he seem to see you? What seemed to be the reaction of the client to the interview?
- When did the interview seem to falter? When was it going smoothly?
- Did the client at any time show signs of resistance, irritation? What had you said or done just prior to that?
- Did it at any point cease to be an interview and become a conversation, discussion, or argument?
- How could you characterize the relationship between interviewer and client?
- What type of psychological climate was set for the client? Give instances to support your thinking.
- If possible, find instances when your responses were (a) probing, (b) interpretative, (c) understanding, (d) evaluative, and (e) supportive. Try to describe the client's reaction following each type of response.

Recalling and analysing some of your own affect (thought, feelings, and attitudes) during the interview process is important for at least two reasons. First, it may be an additional source of information about the client that may be very helpful in planning treatment and in dealing with the client during counseling. Subjective information is often just as useful as objective information. If, for example, you *consistently* get angry, frustrated, or uncomfortable with the client when he behaves in a certain way, the chances are that other people may have the same reaction. If your (the counselor's) impulse during these moments is to reject or punish the client, other people may have the same impulse. When the client wonders why he is always being rejected or punished by others, you may have the answer — maybe because he is consistently doing something that makes you want to punish him.

The second reason it is important for you to be aware of your affect (subjective impressions), as it relates to specific client behaviors, is that it may block or hinder your effectiveness. The result may be your feeling terribly frustrated and inadequate. Very often, this has more to do with the client than your *being* inadequate. The counselor should realize that he is not usually working with a "healthy" neurotic who keeps appointments, participates fully in treatment, and responds well to "talk therapy." More commonly, the client will be resistant, negative, and not willing to explore his own intrapersonal dynamics. His motivation to change may often be deadened by the drugs he has been taking, or the experiences he has had.

In either case, the importance of your own feelings and thoughts about the client cannot be underplayed. Your reactions during the interview might be the basis for a discussion during supervision. Rather than complain about the client and his inability to change or cooperate as much as you would like him to, use your reactions to him constructively.

The case history summary, which follows in the next section, will help you understand the need for documentation of both objective and subjective information about the client.

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THE CASE HISTORY

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THE CASE HISTORY

The use and importance of case history preparation has been well established in medical treatment. A doctor's successful diagnosis and treatment often depend on an accurate and thorough case history. Important diagnostic information may frequently come from seemingly insignificant and irrelevant questions. Therefore, medical students are taught very early in their clinical training to obtain and validate information from patients who may be reluctant to answer seemingly picky questions.

There are at least two important reasons why drug abuse treatment programs should have all necessary information obtained from the client organized and in writing. First, it is a handy catalogue of factors contributing to the client's drug abuse, along with resultant symptoms and effects. The organization of information forces you to review data from the assessment interview, sort out meaningful from extraneous facts, and make some preliminary decisions about the client's needs and what treatment will be appropriate.

Secondly, the case history documentation provides information on the client's background and a description of treatment that will be invaluable if a change of counselors is necessary. The client's case history not only provides the new counselor with necessary basic information and reduces the need for the client to repeat himself, but also minimizes the interruption of the client's treatment program.

CASE HISTORY FORMAT

Information obtained in the assessment interview constitutes the basis for the written case history. Use of the interview form provides for the preliminary organization of the data according to each of the four content areas covered. Some of the items in each category may vary according to individual program needs or counselor practices.

Time should be allowed after each interview for organizing and recording information collected during that interview. This applies whether you rely on the use of notes, recordings, or memory alone. To facilitate recording such information, a sample format for case history documentation based on the Assessment Interviewing Guide (AIG) is presented here.

The case history outline is self-explanatory. Section I contains whatever client identifying data is required by program procedures. The amount and type of information contained here varies from program to program. Some of the information may have been collected prior to the assessment interviews and be contained elsewhere in the client's case record. You may want to verify some of the information (such as Social Security number or telephone number). Verifying the information with the client may provide a lead into a line of questioning in any one of the four content areas.

Sections II through V should simply summarize the information gathered in each of the four content areas during the assessment interviews. You will note that each section allows for a sorting out of "facts" from "impressions." Facts in this sense means both what is really known about the client from other sources (e.g., arrest records, lab tests, education, etc.) and what the client says about himself (e.g., *I never met a girl I didn't like, I don't like being asked all these questions*, etc.). You may want to qualify some of his written com-

ments with phrases such as *client claimed . . .* or *client said . . .* This suggestion is made because in some instances the client's report may not be totally reliable. It is not essential that you commit to writing every single detail such as names, events, or places. You are advised to use your own discretion. If the case history or case notes contain inaccurate information, the client, or even the program, could be in serious trouble if the information either leaked to others or was subpoenaed.

The impressions part of the above sections offers you an opportunity to speculate about the client's dynamics, the quality of the interaction during the interviews, and your own subjective experience of the client. Subjective impressions may often be as useful as objective information.

The last section of the case history outline provides room for information that does not conveniently fit into any of the above areas. If other records or information, such as psychological testing, academic records or a behavioral assessment inventory are available they may be attached. If additional information is forthcoming, it should be noted in the summary section.

Once the information from the assessment interview has been organized and recorded, the case history serves as the reference document for treatment planning.

Following is a case history outline. A broadened version, with space for writing, is provided in the appendices.

CASE HISTORY OUTLINE

Counselor's (Interviewer's) Name _____ Date _____

I. Identifying Data

Client's Name _____ Social Security No. _____

Alias(es) or Nicknames _____

Home Address _____

City _____ State _____ Zip Code _____

Phone _____

Date of Birth _____ Age _____ Sex _____

Ethnicity _____ Marital Status _____

Dependents _____ Relationship _____

Current Employment _____

Other identifying data as required by program _____

II. Readiness

Facts:

Impressions:

III. Relationships

Facts:

Impressions:

IV. Rationality

Facts:

Impressions: (Also see Behavioral Assessment Inventory)

V. Resources

Facts:

Impressions:

VI. Summary

Other Pertinent Data: (CODAP), drug use history, etc.)

Other Impressions:

VII. Information Attached: Behavioral Assessment Inventory, medical record, psychological record, academic record, etc.

TREATMENT PLANNING

PLATE 10

TREATMENT PLANNING

As mentioned earlier, the results of the assessment interview and the preparation of the client's case history provide the basis for developing a sound treatment plan. The effectiveness of such a plan will depend to a large extent upon regular treatment entries plus constant review and modification based on the client's participation and changes in his behavior.

Since a plan that is beneficial to one client may have little or no value for another, developing an *individualized* treatment plan is vitally important. Such a treatment plan may offer the client well reasoned, tailor-made goals that will enhance the possibility of his success. Even a personalized treatment strategy may have a different effect on an individual at different points in the program. Treatment planning provides a constant input of information that enables the counselor and other staff members to modify treatment as the client's behaviors and expectations change. Treatment planning done in consultation with others has the benefit of providing a variety of perspectives: you (as the case manager) hear staff opinions and viewpoints that may differ from your own or that you may not have considered. Conversely, when your views are similar to those of the treatment panel, the treatment planning process serves to support and validate your assessment and decisions regarding the appropriate course of treatment. Another reason for developing individualized treatment plans relates to the requirement stated in the Federal Funding Criteria for Treatment Services that programs develop and maintain such plans. The plans should designate a specific counselor, contain a statement of short- and long-term goals, describe the nature and extent of the counseling involved, and describe the supportive services that will be utilized. A final reason for treatment plans is to provide a basis for program evaluation. That is, external evaluators can review treatment plans and obtain some idea of the nature, frequency, and quality of treatment activity.

In light of the above factors, a treatment plan should be viewed as a dynamic, continuing process rather than as a cut-and-dried prescription for medication or therapy. The client is in a state of constant personal evolution; an effective treatment plan will be flexible enough to accommodate the client's changes.

TREATMENT PLAN FORMAT

As with the case history outline in the previous section, the treatment plan format offered here is a simple one that various programs or counselors may want to adopt or modify. Section I calls for minimum information; different treatment modalities may require more.

Of primary importance in the treatment plan is the statement of long-term and short-term goals. Long-term goals may be at any undefined point in the future and need not include, at this time, all of the specific steps the client must take in order to attain the goal. The long-term goals, however, should be realistic and within the client's reach. If, for example, the client wants to become a psychiatrist but has to complete his G.E.D. first, this would indicate poor planning unless the client is young, highly motivated, very ambitious, and a high achiever. Even if this were true, you should probably negotiate more realizable, intermediate-range goals. Within long-term goals there should be an indication of the client's responsibility in reaching the goals. If, for example, the client wants to open a small

business, he should be willing to investigate on his own what running a small business involves. Long-term goals need not be *fully* realized while the client is participating in the treatment program. If the client wants to remain free of illicit drugs for the rest of his life, he need not stay in the program that long. And finally, long-term goals may be flexible and negotiable, since their primary purpose is to assist the client to make a commitment and, more importantly, to give direction to his treatment. Short-term goals are steps in that direction.

Unlike long-term goals, short-term goals are very specific, very realistic, and have a definite time limit. Generally, outpatient clients should attain their goals within 90 days, residential or day-care clients within 30 days. Short-term goals should be specified in objective, observable, behavioral terms and should include a clear statement of what the client will do in order to reach each goal. If the client has a long-term goal of getting a G.E.D., his short-term goal may be preparation for the G.E.D. by attending classes X number of times a week within a given period and demonstrating satisfactory performance in class. If a client is resistant to treatment and not motivated to participate as actively as other clients, a short-term goal might be for him to participate in low-key programming such as a seminar or a social activity (even playing pool once a week) with supportive counseling once a week until he is ready to negotiate something else. The point here is that both you and the client should guarantee success by keeping short-term goals modest and attainable. Some short-term goals may be nonnegotiable, such as clean urines or abiding by program rules.

In any case, when short-term goals are stated in observable, behavioral terms, and when they involve some responsibility on the part of the client, progress in treatment can be gauged by attainment of or failure to reach the goals rather than by saying *the client is getting better* or *the client is getting worse*.

The last section of the treatment plan outline offers an opportunity to justify your treatment plan based on what you learned about the client from the assessment interviews and through preparation of the case history. If the justification was correct, you have documented your successful hunches. If the justification was incorrect, you have a reminder of what to avoid next time.

THE TREATMENT PLANNING PANEL

A treatment planning panel may be composed of the various staff members who give treatment and other services to the client. (*Treatment panel* is used here in the same sense as *case conferences* or *staffing a case*.) Because of the regularity and depth of your contact with the client, you occupy the central role on this panel. The information that you have acquired through the assessment interview puts you in the most advantageous position for making treatment recommendations. You are responsible for presenting these recommendations, along with the client's history, to the treatment planning panel.

Standard medical procedures and, usually, governmental regulations for Federally funded programs, require that the supervision of treatment be carried out by a mental health consultant who is a certified and licensed professional. This consultant serves as reference for and gives official sanction to the counselor's judgments.

The remainder of the treatment planning panel consists of persons representing other program components or services. These include vocational rehabilitation, social services, medical services, legal assistance, and any other areas that may be appropriate or relevant to the treatment planning process for a particular client.

The actual treatment planning review may begin with your presentation of the client's case history and your recommendations for treatment. The panel then reviews the material that has been presented and confirms, amends, or revises your treatment recommendations. When the panel completes its review, you record the results on the treatment planning form. You then "negotiate" the treatment plan with the client.

Your role in the treatment planning process is a delicate one; you occupy primarily a middleman position. You and the client must agree on the treatment plan or else the entire process becomes little more than paperwork. You must negotiate the plan with the client, but this must be done in accordance with sound therapeutic judgments if the planning panel is to confirm the treatment recommendations. Competent treatment planning thus requires that you not only be adept at assessing the client and his needs but be competent at negotiating treatment goals as well.

Date of next review: _____

Counselor: _____

TREATMENT PLANNING GUIDE OUTLINE

Client's Name: _____ Date: _____

Client Number: _____ AITP Counselor: _____

Assigned Counselor: _____

I. Treatment:

Current treatment modality: _____

Medication: _____ Dosage: _____

Type and frequency of counseling: _____

Other supportive services & activities (frequency of each):

Definitions

Goals: The aims, purposes or end products to be accomplished as a result of treatment, based upon the client's needs and the program services.

Tasks: The activities, actions, behaviors or steps the *client* must do or take in order to reach the goal. These are objective and observable, and become the basis upon which progress notes are written.

II. Long-Term Goals:

III. Short-Term Goals (90 days or less):

Goals	Tasks

Comments (Rationale for plan):

Note: NIDA Federal Funding Criteria require that outpatient programs review treatment plans at least once every 90 days. All other modalities (essentially residential programs and day care) must review at least once every 30 days.

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CONFIDENTIALITY

RETRY PAGE

CONFIDENTIALITY

It has always been one of the counselor's major responsibilities to develop a relationship with the client that is conducive to self-disclosure and to assure the client that that information will be held in the strictest confidence.

The establishment of a trusting counselor-client relationship is appropriately discussed in the sections concerning the development of interviewing skills. There are, however, sensitive areas that are best covered here. A clear understanding of these areas will offer you insight into the nature of your work, help you develop more realistic expectations, and provide a reference point to measure progress. The information that you need from a client may be psychologically sensitive (certain issues may be painful to face or discuss); it may also create personal dangers due to the possibility of reprisals in the streets or of prosecution by the courts.

A client is sometimes reluctant to divulge personal information because he fears disclosure or a breach of confidentiality. Such fears are easily understandable, but must be allayed if treatment is to be effective. The client should be aware that firm regulations exist to protect both clients and professionals. A mark of a good counselor is the ability to develop a trusting relationship in spite of these constraints.

The type of information generated and recorded by drug abuse treatment programs is frequently of a confidential nature; therefore, the potential exists for violating a client's rights to confidentiality. Counselors learn a great deal about a client's personal life during the treatment process. Developing case histories and treatment plans on the basis of the Assessment Interviewing Guide increases the potential for violating confidentiality, since a good case history contains a great deal of information of a personal and highly sensitive nature. The use of case histories and treatment plans implies that such information will be entered in written form. Because of this, it is important that the client understand how this information is legally protected and how the treatment facility ensures this protection.

Current rules and regulations, *Confidentiality of Alcohol and Drug Abuse Patient Records, General Provisions* (**Federal Register**, Vol. 40, No. 127, July 1, 1975), provide you with legal support for dealing with the client's misgivings.

Your responsibilities with regard to the client's records lie in two areas: (1) the use, storage, and security of written records, and (2) the protection of information from illegal (and/or unethical) oral disclosure. Responsibility in the first area is straightforward: you must be accountable to the staff person charged with maintaining and securing client records. The project must have a storage and acquisition system that satisfies Federal laws and regulations. Since many project components will use the clients' records (counseling for treatment, other components for cost analysis, billing, job training), a well organized and well run recordkeeping system is essential. You, as one of many who records and utilizes information, must observe project policies and procedures in keeping records.

The second area of responsibility is perhaps not so easy to fulfill; seemingly inconsequential conversations could result in the unintentional but nevertheless illegal disclosure of confidential information. A client may only be discussed during actual treatment consultation and then only with appropriate staff persons. While the confidentiality

regulations are very explicit and quite strict on the subject of oral disclosures, you are also bound by your own moral code and professional standards of conduct (such as those developed by the American Psychological Association or other professional organizations in human services). In essence, *professional standards require that you act on behalf of the client and behave in the client's best interest.*

The Federal regulations apply to all records of identity, diagnosis, prognosis, or treatment and "include any information, whether recorded or not, relating to a patient . . ." (p. 27805 [11]).* Such information includes facts pertaining to attendance, physical whereabouts, and to the client's status. In general, the best policy is to simply decline any discussion about a client unless proper written authorization is obtained.

Since the project director is legally responsible for the project, it is not necessary for a counselor to respond to any request for disclosure of patient records or information; this includes subpoenaed information or information sought by coercive means. If a director orders you to provide information, either written or oral, it is certainly to your advantage to have the order put in writing.

The client's permission to divulge information must be in the form of a *written* consent in all except extraordinary circumstances, such as medical emergencies or by specific court order. Even in cases where information may be obtained without written consent, there are strict regulations governing the nature and extent of the disclosure. To protect oneself and the client, the best policy is to obtain a written release. Once such consent is obtained, however, it should be turned over to the records manager whose duty it is to maintain such releases as part of the client's records.

Information is occasionally sought through secret or covert means. Those seeking the information may be law enforcement officials, creditors, or persons with extra-legal intent. In general, confidentiality regulations prohibit the use of undercover agents and informants in drug abuse programs, or the disclosure of information to such individuals. It goes without saying that disclosures not associated with law enforcement agencies are equally prohibited by and subject to the regulations.

In summary, confidentiality means two things for you: developing a relationship of confidence with the client, and maintaining records with such professional decorum that nothing, either spoken or written, is handled in such a manner that would violate that confidence (or the law).

A synopsis of the confidentiality regulations, which were set forth as part of the Drug Abuse Office and Treatment Act of 1972 and further amended in July of 1975, is presented on the following pages. The reader is warned not to consider himself an expert when he completes this section. On the contrary, any questions concerning these regulations should be handled by a lawyer. It is our intention here to give you sufficient information to know that a lawyer should be consulted.

*Department of Health, Education and Welfare, and Special Action Office for Drug Abuse Prevention. Confidentiality of Alcohol and Drug Abuse Patient Records. **Federal Register**. Friday, July 1, 1975, 40 (127).

CONFIDENTIALITY OF DRUG ABUSE PATIENT RECORDS

In the area of drug abuse, most records of treatment are entitled to strict confidentiality and nondisclosure. Under 21 U.S.C. 1175, Section 408, of the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), records of the "identity, diagnosis, prognosis, or treatment of any patient" in relationship to drug abuse treatment in hospitals receiving *any* type of Federal assistance must be kept confidential unless specific exemption of the act allows disclosure.

In its legislative report on the 1972 Drug Abuse Act, Congress states:

Every person having control over or access to patients' records must understand that disclosure is permitted only under the circumstances and conditions set forth in this section (21 U.S.C. 1175). Records are not to be made available to investigators for purpose of law enforcement or for any other private or public purpose or in any manner not specified in this section.

Recently, the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention (SAODAP) promulgated new detailed regulations interpreting the extent of this mandate for confidentiality of patient records. In the preamble to these regulations, HEW and SAODAP reiterated Congress' view that disclosure of patient records was to be limited so as to diminish any impediments to voluntary treatment for drug abuse. A copy of the Special Action Office regulations may be found in Appendices; it should be consulted for information regarding specific situations. Some highlights of these regulations are:

- Appropriate precautions must be taken to provide security for patients' files dealing with drug abuse treatment. Records shall be kept in a secure room, locked file or similar container. Written procedures should be in effect to regulate and control access to such files.
- These regulations apply to any given individual over any period of time, irrespective of commencement date, provided the treatment did not end before March 21, 1972, in the case of drug abuse, and before May 14, 1974, in the case of alcohol abuse. The records of a person whose application is rejected or withdrawn are fully as much covered as those of active patients.
- Any disclosure should be limited to the extent required to serve a lawful purpose or bona fide cause (e.g., medical emergency). In essence, this means that the only information that should be released is that which is necessary to bring about the successful conclusion of the purpose for which the information is being released. Hence, blanket disclosures of all records should be discouraged; only records pertinent to the cause for disclosure should be released.
- The prohibition upon unauthorized disclosure applies whether or not the person seeking the disclosure already has the information, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other basis for disclosure not expressly authorized in the regulations.
- Such prohibition covers all information including attendance, the patient's status in the program, and physical whereabouts of the patient. The disclosure of negative information (e.g., whether an individual is not or has not been attending a program) is equally prohibited.

Disclosure with the Patient's Written Consent

The Drug Abuse Office and Treatment Act does allow disclosure with the patient's *written* consent. A patient's record, identity, diagnosis, prognosis and details of treatment should not be divulged to any Federal, state or local authorities (except for purposes of research, audit, and/or evaluation) without such consent. For example, a telephone call alerting the police to the drug abuse would violate this regulation and thereby violate the law.

The patient's written consent is required in any of the following situations:

- For any disclosure of treatment information to parole or probation officials and/or court officials (If, however, participation in treatment is a condition of pretrial or posttrial release, the patient may consent to unrestricted communication between the program and the court and probation and parole officials.)
- For any disclosure of information to the patient's attorney
- For disclosures to medical personnel or to treatment or rehabilitation programs
- For disclosures to third party payers and funding sources
- For disclosures to family or individuals with whom the patient has a responsible personal relationship
- For any disclosure to employers and employment agencies (In the case of information to a prospective employer, the following conditions must be met: (1) The patient must submit a *written* and *signed* request that identifies the prospective employer. (2) The person supplying the information must verify the request with the prospective employer. (3) The information supplied must be limited to the extent that it meets (but does not exceed) requirements of the purpose for which it is being furnished. (4) No information shall be furnished unless there is credible belief that the information is to be used for the drug abuser's rehabilitation.)

In any situation not otherwise specifically provided for in these regulations, where written consent is given in accordance with the regulations, disclosure may be made for the benefit of the patient if all of the following criteria are met: (1) There must be nothing in the written consent or the circumstances surrounding it to indicate that the consent was not given freely and without coercion. (2) Such disclosure must not cause harm to the patient. (3) Such disclosure should not be injurious to the program-client relationship. The program director has final responsibility in determining if these criteria have been met and whether disclosure should be made,

Circumstances considered to be beneficial to a patient include, but are not limited to, those in which the disclosure may be of assistance to the patient or his immediate family. Examples include welfare, Medicare, unemployment, workmen's compensation, insurance benefits, pension or retirement benefits, and issues pertaining to the patient's interests in any civil, administrative, or other legal proceeding.

In a form for consent to disclosure, the following eight items are required:

- The name of the patient about whom information is being disclosed
- The name of the program making the disclosure
- The name(s) of the person(s) to whom the information is to be disclosed
- A written and dated release for the disclosure of the information
- The signature of the patient or other authorized party granting permission to release information
(General releases, signed prior to specific requests for information, for example, the type of release required prior to receiving treatment, are not acceptable.)
- A statement of the purpose and need for disclosure
- A description of the extent and nature of the information to be disclosed
- A statement that the consent may be revoked at any time by the patient and a specification of the date, event, or condition upon which it will expire without expressed revocation
(Any redisclosure normally requires the further specific consent of the patient, and is subject to the same restrictions governing the original disclosure.)

Consent with Respect to Minors and Incompetent or Deceased Patients

Consent must be given by both the minor and his parent, guardian, or other legally authorized person; any disclosure made after the patient has ceased to be a minor may be consented to only by the patient. In states where treatment is authorized without parental consent, any consent required for disclosure may be given only by the patient.

In a situation where a state requires parental consent and a minor applies for treatment on his own behalf, the fact of such application may not be disclosed to his parents or guardians without his consent. If the applicant refuses such consent, it must be pointed out that he cannot receive services without it.

In states where parental consent is not required for treatment, no inquiry may be made regarding the financial status of the patient's family, nor may any bills or requests for payment be sent, directly or indirectly, to the patient's family or guardians without the written consent of the patient. Such consent may not be made a condition for receipt of services except in the case of a program that is not required by law to furnish services irrespective of ability to pay and does not in fact hold out itself as willing to furnish such services.

If a minor lacks the rational capacity to give consent (either due to extreme youth or mental or physical incapacitation), disclosures may be made to parents or guardians in situations that pose considerable danger to the patient or applicant. The law states:

When, in the judgment of a program director a minor applicant for services, because of extreme youth or mental or physical condition, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, and the situation of the applicant poses a substantial threat to the life or physical well being of the applicant or any other individual, and such threat might be reduced by communicating the relevant facts to a parent or guardian of the applicant, such facts may be so communicated by the program director or by program personnel authorized by the director to do so. (Section 2.15f)

In the case of incompetents other than minors, consent may be given by legal guardians. The law states:

Where consent is required for any disclosure (for incompetent patients other than minors) . . . such consent in the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs may be given by the guardian or other person authorized under State law to act in the patient's behalf. (Section 2.16a)

Consent for disclosure of information pertaining to deceased persons may be given by an executor, administrator, or other personal representative. In the absence of such representatives, consent may be given by the spouse or, if none, by any responsible member of the patient's family. Any disclosures required by Federal or state law pertaining to death or other vital statistics may be made without consent.

Disclosure to Third Party Payers

A third party payer is defined as any organization or acting agent that pays or agrees to pay for diagnosis or treatment where such payment is on the basis of an individual relationship between the payer and the client or a member of the client's family (in the case of insurance coverage) as set forth by a contract, insurance policy, or similar documents.

Disclosures may be made to third party payers and funding sources only with the written consent of the patient; only information that is necessary for the fulfillment of legal or contractual obligations on the part of such parties may be given. Any information acquired by such parties is subject to the same restrictions covering original disclosures.

Disclosures without Patient's Written Consent

Although the best general rule of thumb to follow regarding disclosures is to obtain written consent whenever possible and for almost all situations, there are a few circumstances under which disclosures may be made without the patient's written consent. If written consent is not given, disclosure is allowed:

- When it is necessary for medical personnel to meet a medical emergency
- When it is authorized by a court order (accompanied by a subpoena), in which case information shall be limited to objective data necessary to meet the purposes for which the order is intended
- When treatment involves the use of any drug determined by the FDA to be dangerous to the life or health of the patient, in which case patient identifying information may be released to the FDA for purposes of notifying patients or their physicians
- For scientific research, management and financial audits, or program evaluation, but without disclosing in any report of such research, audit, or evaluation the identity of the drug abuser

In situations where oral disclosures are made without consent but in accordance with the regulations governing disclosure without patient consent, the program is to provide a written memorandum giving the patient's name, the nature of the emergency, the date and time of disclosure, the nature of the information disclosed, and the names of the individuals making and receiving such disclosures.

The Use of Central Registries

In certain areas of the country, central registries play an important part in treatment programs. The use of such registries, however, is prohibited unless they meet the definition of a permissible central registry and their use is for the purpose of preventing multiple enrollments in drug maintenance or detoxification programs. A "permissible central registry" is defined as a service organization that collects patient identifying information from two or more programs within the same state or not more than 125 miles from the nearest border of such state.

Information Obtained through Supervisory and Regulatory Processes

The following agencies are permitted access to program premises and records for the purpose of carrying out their specific functions in the supervision and regulation of drug maintenance and methadone detoxification programs: (1) Drug Enforcement Administration; (2) Food and Drug Administration; (3) state drug law enforcement agencies; and (4) state health authorities. (Other agencies, for example, funding agencies, may be granted access to records for purposes of audit and evaluation so long as this transaction is consistent with Sections 253 and 254 of the regulations.)

Patient identifying information obtained through these supervisory and regulatory processes may not be used in any registry or personal data bank of any sort, nor may it be otherwise disclosed.

Undercover Agents and Informants

Due to legal circumstances surrounding drug abuse, many patients enter treatment programs with a great deal of anxiety and suspicion. Consequently, the presence of undercover agents and informants can exercise considerable negative effects on program morale and effectiveness. In addition, the purpose of such agents is generally to secure information of the type protected by this legislation.

For the reasons indicated above, no undercover agents or informants may be employed or enrolled in any drug abuse treatment program, nor may the agent's supervisor knowingly permit the infiltration of such programs; the use of informants is equally prohibited. An informant may, however, enroll in a treatment program as a client for his own benefit.

Since there is always a possibility that medical personnel may become involved in the illegal sale of drugs, an exception to the above prohibitions is provided in order that sufficient evidence may be obtained for successful prosecution. In the case where criminal conduct is believed to be carried on by an employee of the program with the program director's knowledge of involvement, a court order may be issued without notice authorizing the use of undercover agents and informants.

Conclusion

All efforts should be made to maintain patient records in the utmost confidence. When there is a need for disclosure, written consent is almost always required with the exception of situations noted specifically in this section. When in doubt, obtain a written consent for the protection of both you and the patient.

It should be kept in mind that the restrictions and prohibitions set forth apply to all personnel, both while in the program and after leaving employment. The same restrictions apply to all outside parties associated with the program (e.g., auditors, researchers, evaluators, third party payers, service organizations) and who are recipients of disclosures. In like manner, redisclosure by individuals within the program or by those associated with the program is protected by the same set of regulations governing original disclosures; the patient's consent is ordinarily needed for each subsequent disclosure. The regulations also require that generally when a disclosure of information is made, the information should be accompanied by a statement informing the recipient of his obligation to guard the confidentiality of the information and not to disclose it except as authorized by the regulations.

Any violations of these laws or regulations, according to provisions made by Congress, can result in penalties of not more than five hundred dollars (\$500.00) for the first offense, and five thousand dollars (\$5,000.00) for each subsequent offense. Subsequent offenses need not be identical to the first violation but can pertain to any violation under this section.

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PSYCHOMETRIC TESTS

PSYCHOMETRIC TESTS

The interviewing procedures presented here are designed to help assess clients' treatment needs. Interviews, however, represent only one of many assessment techniques available. Assessment is a process that takes place constantly and on many different levels. Every time you make a judgment about a client on the basis of appearance, mannerisms, speech, or behavior, an assessment is being made. Each time you consult a client's records to review past behavior, you are making an assessment. Conversations with a client's friends, relatives or other involved individuals, produce an assessment. In short, any information you acquire to help form an impression of the client's problems, personality, or potential is a part of the process of assessment.

Since there are often time constraints, particularly during the intake process, your initial assessment may be faulty or incomplete. It is often difficult to know, for example, how intelligent, friendly, or trustworthy a client is on the basis of one interview. It may even be difficult to ascertain the client's state of rationality or his general emotional tone; clients may be too nervous or anxious to create a good impression, and reluctant to reveal true feelings or behavior.

Psychological tests provide an important adjunct to observation and interviewing, and help to compensate for some of the shortcomings of these two assessment techniques.

Although tests are a valuable tool in the assessment of treatment needs, they should never be used or relied upon as a substitute for careful interviewing, nor should they be administered or interpreted by untrained personnel. No test is better than the person who interprets its results. The potential difficulties arising from incautious use of such tests demand that they be administered and interpreted with the utmost care.

Even though you may not be trained to administer or interpret psychological tests, it is important that you know something about tests most commonly reported in clients' records. It is also important to know what tests are available for which diagnostic purposes so that you can request tests for clients who are difficult to assess. The following types of tests are most commonly used to supplement other diagnostic procedures:

- Personality tests — objective
- Personality tests — projective
- Intelligence tests
- Vocational tests

PERSONALITY TESTS—OBJECTIVE

Objective tests of personality are used widely for both treatment and research. They are designed to obtain information about many different personality traits quickly, simply, and inexpensively. Most of these tests are based on true-false or multiple-choice questions that can be answered on a self-administered test form, usually in an hour or less. They can be given to clients either individually or in a group and do not require a trained staff member for either administration or scoring. Because these tests are inexpensive and simple to use,

they have been administered to many thousands of people prior to, during, and after treatment. (An overall picture of the client's scores on each of the many test scales, a test profile, is obtained.) By comparing a client's test profile with profiles obtained from other clients and research subjects, a trained person can learn a great deal about a client's treatment needs. All of these tests require that clients respond to questions truthfully, but most of them have built-in validity indicators or "lie detector" scales designed to identify clients who try to create an unusually favorable or unfavorable picture of themselves. The most widely used tests in this category are the Minnesota Multiphasic Personality Inventory (MMPI), the California Psychological Inventory (CPI), the Edwards Personality Preference Schedule (EPPS), and the Adjective Check List (ACL).

Minnesota Multiphasic Personality Inventory (MMPI)

Known familiarly as the *MMPI* or the "Mult," this is the oldest, best known, and most widely used test in this category. It consists of 566 true-false questions such as *I like to read mechanics magazines* or *My sex life is satisfactory*. It is scored by comparing each client's answers to the answers given by people with known psychiatric problems. For example, a client would receive a high score on the scale measuring *Depression* if his answers were the same as the ones given to these questions by people receiving treatment for depression.

Although the questions seem straightforward and vulnerable to deceptive responses, it is difficult for clients to create the impression they want. For example, most people would think that answering *true* to the question, *I often cross the street to avoid meeting someone I don't like* might be an indication of paranoia. In fact, diagnosed paranoid clients are more likely to answer *false* to this item. The important thing to remember about this test is that the client responses *per se* are not as important as whether or not the responses are similar to those given by people with certain problems.

As an assessment tool for treatment planning, the MMPI can be particularly useful in the identification of clients who may be likely to commit suicide or to be dangerously aggressive. It is also extremely useful in the detection of psychosis and in the assessment of a client's potential for benefitting from psychotherapy. In the hands of a skilled interpreter, it may be further utilized in the detection of organic disorders and psychiatric problems.

California Psychological Inventory (CPI)

The *CPI* was developed from the MMPI and has many of the same questions. It is somewhat shorter than the MMPI and takes a little less time to complete. Since it focuses on healthy aspects of the personality, rather than on psychopathology, it is less commonly used as a diagnostic tool. For this very reason, however, it is an excellent test to use in conjunction with the MMPI to obtain a more balanced picture of a client's strengths and weaknesses.

As in the MMPI, clients are scored on the CPI by comparing their answers with those given by individuals with specific personality assets. For example, the test profile for the CPI includes scores on *Self-control*, *Responsibility*, *Tolerance*, *Flexibility*, and *Social Presence*. It also taps such areas as clients' *Intellectual Efficiency* — which indicates not how smart they are, but how well they use whatever intelligence they have — and such traits as *Achievement via Conformity* and *Achievement via Independence* — which indicate whether clients function better on their own or as part of a group. Clearly, these are the important factors that should be taken into consideration in any treatment planning process.

Edwards Personal Preference Schedule (EPPS) Adjective Check List (ACL)

Although they are constructed quite differently and call for different kinds of responses to the test items, these two inventories are discussed together because they both provide information about the client's personality traits and needs. Instead of focusing on problems or personality assets, however, these tests yield scores that reflect the client's self-image.

The *EPPS* is based on a series of multiple-choice questions in which clients are asked to choose which of two alternatives they would prefer. The *ACL* consists of a list of 300 adjectives from which the client is asked to select those that describe him. Both tests take considerably less time to complete than either the *MMPI* or the *CPI*. The *ACL* is particularly easy to administer because it takes no more than ten or fifteen minutes to complete and is considered enjoyable by most clients.

Personality profiles based on these tests give information about clients' *needs* for assertiveness, dependency, aggressiveness, helpfulness, and for praise or punishment. Again, because these tests do not focus on psychopathology, they are less commonly used in diagnostic assessment than the *MMPI*. However, both are useful in diagnosis because they tap various aspects of the personality that might otherwise be overlooked. Using such tests, it may be possible to discover that an apparently fiercely independent client would like nothing more than a relationship in which he could be dependent. The value of such information in treatment planning cannot be overestimated.

PERSONALITY TESTS — PROJECTIVE

Projective tests of personality are based on the simple idea that a person will tell you something about *himself* (will *project* aspects of his personality) when asked to use his imagination. Thus, just as one person describes a bottle of wine as half-full and another describes the same bottle as half-empty, projective testing assumes that different people will see things differently or interpret things differently according to their particular personality traits.

In contrast to objective tests, projective tests must be administered and scored by highly trained personnel. Except under special circumstances, usually in research, projective tests must be administered individually by the same person who will later score and interpret the results. Projective testing, therefore, is a time-consuming and expensive undertaking. In some mental health settings, a battery (or group) of projective tests is administered routinely to all clients at the time of treatment intake, but in most cases projective tests are requested to accomplish specific diagnostic tasks. In drug abuse treatment, they should be used primarily with clients who are suspected to be psychotic or organically impaired and, to a lesser extent, with clients who appear severely depressed or potentially violent or suicidal. The most widely used projective tests are the Rorschach, the Thematic Apperception Test (TAT), the Bender-Gestalt, and the Sentence Completion Test.

Bender-Gestalt

The *Bender-Gestalt* is used almost exclusively to determine the nature and extent of organic impairment or brain damage, and asks clients to reproduce from memory a series of geometric figures. The other projective tests involve the client in some imaginative activity, and differ from one another primarily in the manner in which that activity is described.

Rorschach

The *Rorschach* was the first projective test developed and it is probably still the most widely used. It is often referred to as the *ink-blot test* because clients are shown ten cards (some in color, some in shades of black, grey and white) that resemble patterns made by pouring ink in the fold of a piece of paper and smearing it about to make an abstract design. The cards are presented to clients one at a time, and they are asked to describe what they see in each card. Scoring and interpretation of the Rorschach is based on what the client describes, how many different things are seen, and most important, on the basis of where each thing is seen and why it appears to the client the way it does. To give just one example, some clients may focus their attention on the whole blot and describe a scene made up of many parts; others may concentrate on some minute detail of the blot or describe each separate part as if it stood alone from all the rest. To the trained diagnostician, these differences in perceptions of the Rorschach cards may help assess various aspects of personality or pathology that may otherwise be extremely difficult to identify.

Thematic Apperception Test (TAT)

Unlike the Rorschach, in which clients are asked only to describe what they see, the *TAT* calls for clients to make up stories. They are presented with a series of drawings and photographs of people and places, and asked to tell a story about what they see, what has led up to it, and about what will happen next. In some of the pictures it is difficult to make out clearly what the characters are doing, whether they are men or women, or what some of the objects or places are. Thus, because the pictures are highly ambiguous, people see them differently and tell quite different stories.

The scoring and interpretation of the *TAT* is based on many things, including the way each client interprets the pictures themselves. But, most important are the themes of the stories told. Again, to give but one example, some clients may tell stories in which the main character does things because of inner needs and wants, because things are important to that character. Others may tell stories in which the main character does things only because of external pressure or to satisfy the wishes of others he wants to please. The *TAT* gives an unusually rich picture of clients' innermost thoughts and beliefs about the way the world works. In the hands of a skilled diagnostician, and particularly when it is given along with the Rorschach, it can be an extremely useful diagnostic tool.

Sentence Completion Test (SCL)

The *SCL* is the simplest and most straightforward of the projective tests described; it requires little explanation. Clients are given the beginning of a sentence, called the "stem," and are asked merely to complete the sentence. For example, a stem common to a number of sentence completion tests is *My mother . . .* If a sentence completion test were designed specifically for use in a drug abuse treatment program, it might include the stem *Since I started using drugs . . .* In short, stems are designed to elicit answers from clients about issues that are relevant to their feelings, attitudes, and behavior. Many such tests are available or can be modified or designed to meet specific program needs.

INTELLIGENCE TESTS

Although it is very difficult to define intelligence operationally, many tests have been developed to measure it. Most of these tests were originally developed for educational use to assess students' abilities, but today their use has been extended to employment screening and treatment planning as well.

In general, intelligence tests compare an individual's ability to perform certain intellectual tasks against the performance of a large number of other individuals. If his performance exceeds the average score for his age group, he is said to be "above average" in intelligence.

The form and content of such tests may vary considerably but, in general, they are concerned primarily with such things as memory, verbal skills, quantitative skills, and problem-solving abilities. Some also measure the ability to perform a number of tasks involving nonverbal abilities such as maze problems, jigsaw puzzles, and similar tasks. As operationally defined in these tests, intelligence is thus viewed not as a single attribute but as involving many different levels of intellectual functioning.

There is good reason to believe that the ability to perform well on intelligence tests may be, at least partially, a function of the individual's educational and socioeconomic background. Since many of the items require the use of skills acquired through formal education, the tests tend to be biased against those with little or no educational attainment. Similarly, many clients from racial minorities and from impoverished backgrounds tend to do poorly on these tests even if they have a high degree of native intelligence. Also, clients who are unaccustomed to taking tests or who become anxious in a testing situation may perform below their true capacity on such tests. For these reasons, it is important to be sure that intelligence tests are carefully administered and interpreted. Used improperly, they can do much damage; used correctly, they can add significantly to the treatment planning process. Two of the most commonly used intelligence tests, the Stanford-Binet and the Wechsler Adult Intelligence Scale, will be discussed here.

The Stanford-Binet Intelligence Scale

Probably the most well known of all psychological tests is the *Stanford-Binet Intelligence Scale* developed in 1890 by Alfred Binet and later expanded by Lewis Terman (of Stanford University) in 1910. Binet was the first to devise a method for distinguishing between "bright" and "dull" children. The test is designed to measure the intelligence level of children (from age two) and adults. Norms were established independent of minority groupings, but these have since been somewhat modified. Because of this and the problems indicated above, caution should be used in interpreting scores derived from such tests.

The Stanford-Binet operationally defines intelligence in terms of seven major attributes or content areas. They are:

1. Language: the naming of objects, rhymes
2. Reasoning: orientation, verbal absurdities
3. Memory: sentences, numerical sequences
4. Conceptual: similarities, proverbs
5. Social intelligence: comprehension, picture absurdities
6. Numerical reasoning: making change, ingenuity
7. Visual-motor: form board, square copying

The Stanford-Binet was developed with the idea that the mind functions as an interwoven unit, with each of the above facilities contributing to one's total intellectual functioning. Since Binet viewed intelligence as a steady growth process, he proposed a scale or ladder of tasks. The scale is constructed so that each successive question is more difficult because the testee gains experience by solving the previous items.

In administering the tests, the examiner attempts to start the subject on easy tasks (questions), usually those at a level of a year below his actual, chronological age (lower if he is suspected to be below average). The subject moves upward, level by level, until at some level he fails all the subtests. Levels are spaced six months apart for children from ages two to five, one year apart for those from age five, and even more widely apart for subjects above the age of fourteen.

The level reached on the ladder is called the mental age. The intelligence quotient is a ratio determined by expressing the chronological age in months, dividing it into the mental age in months, and moving the decimal point two places to the right. Therefore, a child of chronological age (CA) seven (84 months) and mental age (MA) seven, would thus have an IQ of 100; a child of CA ten (120 months) and MA twelve years six months (150 months) would have an IQ of 125, and so on.

Although the Stanford-Binet may be used with adults as well as children, it is most commonly used with children. The above discussion, then, may be referenced when reviewing a client's academic record that reports Stanford-Binet test results of the client at an early age. The more commonly used measure of adult intelligence is the Wechsler Adult Intelligence Scale.

The Wechsler Adult Intelligence Scale (WAIS)

Since the Stanford-Binet was designed primarily for use with children, there was a need for a more adequate assessment instrument for adults. Responding to this need, Wechsler, in 1955, developed a test more suitable for the adult population. His test, the *WAIS*, became widely accepted and was adopted as the standard assessment instrument by many institutions and individual diagnosticians.

Like Binet, Wechsler viewed intelligence as a complex phenomenon resulting from biological development and experience. Although his conception of intelligence was similar to Binet's, he felt the need to establish separate scores for each of the tasks making up the individual's total performance.

On the WAIS, items are divided into two major categories: verbal and performance. Each category contains a series of subtests designed to measure separate components of intelligence. They are:

Verbal

- Information
- Comprehension
- Arithmetic
- Similarities
- Vocabulary
- Digit span (memory)

Performance

- Block design
- Picture completion
- Picture arrangement
- Object assembly
- Digit symbol

The verbal category subtests are self-explanatory in terms of the tasks required; they are primarily a measure of factual information, reasoning and analytical abilities, and memory. The performance category requires the person being tested to look at various pictures or designs and choose the order in which they should appear. Usually a story is told in three or more cartoon panels presented in random order; the person arranges them in their proper order. The task is one that essentially involves the identification of a complex whole from disorganized parts. These tests make limited demands on verbal ability but, as such, are especially helpful in identifying problems such as organic impairment and educational deprivation.

The procedure for administering the WAIS is comparatively simple; it takes approximately one hour. The examiner is permitted to administer the subtests in the order of his choosing to accommodate the person's interests and reactions.

VOCATIONAL TESTS

Vocational testing is a highly specialized field in which different kinds of tests are used to measure skills, aptitudes, interests, and dimensions of personality that relate to success in different jobs.

The Kuder Occupational Interest Survey (KOIS)

The *KOIS* is a test of vocational interests that has one hundred items. Each item lists three activities. The client must select his most and least preferred activity in each group of three choices. These items come under ten major categories: Outdoor, Mechanical, Computational, Scientific, Persuasive, Artistic, Literary, Musical, Social Service, and Clerical. Based on the pattern of responses, scores are computed on twenty-two different occupational scales such as engineer, farmer, minister, etc. High scores on these scales do not mean that the person is necessarily well suited to a particular occupation, but only that he has a pattern of interests conducive to those occupations.

The Strong Vocational Interest Blank (SVIB)

Another widely used test in vocational assessment is the *SVIB*. It, too, asks for an indication of preferences among a variety of alternatives, but it differs from the Kuder in that it is scored by comparing an individual's answers with those of people who are successful in different occupations. Thus, a person who scores high on the *SVIB* engineer scale, for example, does so because he likes to do the same kinds of things that successful engineers do. Scores on the *SVIB* are harder to fake than those on the Kuder and, partly for this reason, the *SVIB* is considered to be the best vocational interest test available today.

The Differential Aptitude Tests (DAT)

This is a widely used battery of tests designed to measure aptitude for different kinds of work. Included in the *DAT* battery are tests measuring ability to perform a variety of clerical and mechanical skills. A similar and widely used test, the *General Aptitude Test Battery (GATB)* measures, in addition, motor coordination, manual dexterity, quantitative ability, and is designed to ascertain aptitudes to perform tasks required in specific jobs.

Other Tests

In addition to these broad-gauged aptitude tests there are many others that measure specific job-related skills. Of these, the most reliable are "work sample" tests in which individuals actually work on the job for a period of time to determine their ability to perform the required tasks.

Among personality tests used for vocational screening, the Holland system is the most widely used. This test yields scores on six scales: realistic, intellectual, social, conventional, enterprising, and artistic. Based on their test profile, individuals are assumed to be especially well suited for particular occupations. Someone who scores high on the realistic scale, for example, would do well in highly structured jobs involving the use of tools, motors, and other objects. But, they would not do well in jobs involving leadership, close personal relationships, abstract thinking, and verbal interactions. Likewise, someone scoring high on the conventional scale would do well on jobs involving clerical and computational tasks, but would not be well suited for jobs involving aggressive salesmanship, verbal persuasion, or close interpersonal relationships. In the interpretation of results on this and similar personality tests, it is important to remember that high scores on these scales do not mean that the person has the ability to perform the required tasks for the occupations in questions, but rather that he does possess certain traits and predispositions that are compatible with or conducive to the selection of jobs in specific vocational areas.

APPENDICES

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THE ASSESSMENT INTERVIEWING GUIDE

CONTENT AREA 1: READINESS QUESTIONS

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CONTENT AREA 1

I. Readiness

A. What brought the client to treatment?

1. Family pressure
 - a. *In what ways has your spouse or family influenced you to seek treatment?*
 - b. *What does your family think about your being here?*
2. Legal pressure
 - a. *Were you sent here by the courts?*
 - b. *What, if any, legal pressures are bringing you to treatment?*
3. Peer pressure
 - a. *Have any of your friends been in treatment here?*
 - b. *Have any of your friends been in other treatment programs? Which programs?*
4. Street pressure
 - a. *Is something happening on the street drug scene that causes you to be here?*
 - b. *Did you come here for reasons of personal safety?*
5. Job pressure
 - a. *Were you sent here by your employer?*
 - b. *If so, What kind of progress do you have to show in treatment in order to keep your job?*
6. Medical problems

What medical problems brought you to treatment now, if any?
7. Internal pressure
 - a. *Did you decide to come to treatment on your own?*
 - b. *What were the reasons for your decision?*
8. Immediacy
 - a. *What caused you to seek treatment now rather than earlier?*
 - b. *What has changed?*

B. What brought client to this program?

1. Preferred modality

What type of treatment do you expect to receive here?
2. Source of information regarding modality

How did you learn about our program?

3. Expectations

- a. *What are your expectations regarding the treatment methods utilized in this program?*
- b. *Given what you know about the program, what do you anticipate will give you the most difficulty?*
- c. *How long do you expect it will take to get straight? or How long do you expect to be here?*
- d. *What do you expect it will be like for you next week? Next month? In six months?*
- e. *What do you expect you'll be like (behavior) when you are ready to leave treatment?*

4. Sources of expectations (personal contact, friends, rumor)

- a. *Where do your expectations come from?*
- b. *What did friends tell you?*

5. Attitudes, beliefs, fears

- a. *What have you heard about this treatment method?*
- b. *What do you know about other forms of treatment?*

6. Acceptability

- a. *Is this form of treatment acceptable to you?*
- b. *What other treatment did you consider?*

7. Support for client's decision

- a. *How do friends (spouse, significant others) feel about your decision?*
- b. *What things are working against you to prevent treatment?*
- c. *What things are working for you?*

8. Do significant others have an interest in keeping the client dependent?

- a. *Who do you think really cares about what happens to you?*
- b. *How are things and people going to change once you stop using drugs?*
- c. *What changes do you anticipate in your relationships with your spouse (with others) if you stop using drugs?*

Has the client had previous treatment experience?

1. Previous attempts at treatment

What previous treatment have you had for drug abuse, if any?

2. Modality

What was the nature of the treatment?

3. Sequence of experiences (if more than one prior experience)

4. Duration

How long did the treatment last?

5. Consequences

a. *What was it like?*

b. *What changes did it bring about?*

6. Satisfaction

What did you like about the treatment?

7. Dissatisfaction

What did you dislike about the treatment?

8. Reasons for termination

What were the reasons or circumstances for leaving?

9. Who or what was helpful to the client in these programs?

a. *In what way did you find the counselor to be helpful? Not helpful?*

b. *What about the experience did you find helpful? Not helpful?*

c. *What did you gain from the experience?*

If the client gives negative response:

How did you handle it? or What did you do with your anger, hostility, disappointment? (or whatever client said)

d. *What services in the last clinic helped you most? Least?*

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CONTENT AREA 2:
RELATIONSHIPS QUESTIONS

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CONTENT AREA 2

II. Relationships

A. Who is (are) the person(s) to whom the client has been closest?

1. Quality of the relationship
 - a. *Who is the person you feel closest to?*
 - b. *Tell me about this person.*
2. Feelings about the person and the relationship
 - a. *How do you feel about this person?*
 - b. *What do you like best about the relationship?*
 - c. *What do you dislike about the relationship, if anything?*
3. Duration of the relationship
 - a. *How long have you known each other?*
 - b. *How long have you known each other on a close or intimate basis?*
4. Present status
 - a. *Do you associate now?*
 - b. *Do you keep in touch?*
 - c. *How are you getting along now?*
5. Meaningfulness or depth of relationship
 - a. *What do you do together?*
 - b. *What do you talk about?*
 - c. *Have you ever told this person things about yourself that no one else knows?*
 - d. *When (or if) you are in trouble, will this person help you out?*
 - e. *How do you handle disagreements?*
 - f. *Are there some secrets that you can trust this person with?*
 - g. *Are there some secrets that you cannot trust this person with?*
 - h. *Are there some things you can depend on this person for? Not depend on him for?*
 - i. *Can he trust you?*
 - j. *Can he depend on you?*

B. What is the quality of the client's relationships with members of his family?

Specific family members

For all of these, say *Tell me about your _____*.

- a. *Mother (natural, foster, step)*
- b. *Father (natural, foster, step)*
- c. *Siblings (natural, foster, step)*
- d. *Other family figures (grandparents, aunts and uncles, godparents, etc.)*
- e. *Spouse*
- f. *Children*

C. What was (is) the home like for the client?

1. Family

- a. *What were some of the positive things you got from your family?*
- b. *What were some of the negative things you got from your family?*
- c. *Did your family treat you differently from your brothers or sisters? In what way?*
- d. *As a child, were there ever times when you wanted to run away from home? Did you? What were the reasons for your leaving?*

2. Adverse family conditions

- a. *Drug abuse*
- b. *Alcoholism*
- c. *Brutality*
- d. *Incest or other unusual sexual behaviors e.g., pedophilia*
- e. *Suicide*
- f. *Mental illness*
- g. *Compulsive gambling*
- h. *Compulsive promiscuity*
- i. *Criminal behaviors*

3. Unusual family constellations (homosexual or bisexual parents, communal parents, open marriages, etc.)

4. Separation

- a. *Have you ever lost someone who meant a lot to you through —*
 - 1) *death,*
 - 2) *murder,*
 - 3) *suicide,*
 - 4) *divorce or separation,*
 - 5) *incarceration of brothers, sisters, or parents?*

- b. *As a child, were you ever separated from your family due to —*
 - 1) *illness,*
 - 2) *long periods of hospitalization,*
 - 3) *other institutionalization? (e.g., detention facilities, training schools, etc.)*

D. Was the client ever separated from his family and institutionalized as a child?

If the client lived in an institution, inquire about:

- 1. Nature of the institution
 - What kind of an institution or facility was it?*
- 2. Reasons for placement
 - a. *Who was responsible for your being in the institution? courts, family, self, others*
 - b. *Why were you placed there (or why did you choose to go there)?*
 - c. *Did you feel your placement there was the right thing for you?*
 - d. *How do you feel about the people responsible for your being there?*
- 3. Length of confinement
 - a. *At what age did you enter the facility?*
 - b. *How long did you remain there?*
- 4. The client's attitudes towards the facility and its personnel
 - a. *What were some of the things that you liked about the facility? Disliked about it?*
 - b. *What were your feelings toward the people who ran the facility?*
 - c. *What people were the most important to you in the institution? In what way did they contribute to your well-being or development?*
 - d. *How would you describe your feelings about institutions in general?*
- 5. Adverse conditions
 - a. *Drug abuse*
 - b. *Brutality and/or harsh treatment by authorities*
 - c. *Violence on the part of peers*
 - d. *Homosexuality*
 - e. *Physical conditions poor accommodations, harsh practices, etc.*
 - f. *Mental illness and/or suicides*
 - g. *Runaway and turnover rates*
 - h. *Relationships with peers, i.e., was client accepted or rejected by peers?*

E. What is the quality of client's relationship with members of the same and opposite sex?

1. People of the same sex

- a. *Do you have many male (female) friends?*
- b. *On the whole, do you like or enjoy being with men (women) more than women (men)?*

2. People of the opposite sex

- a. *How do you get along with men (women) in general?*
- b. *Which of the sexes do you get along with better? For what reasons?*
- c. *With which do you spend the majority of your time?*

3. Sexual orientation

- a. *What is your major sexual orientation? gay, straight, bisexual*
- b. *What kind of a person do you prefer as a sexual partner?*
- c. *How important do you feel that sex is in comparison with other aspects of a relationship?*

4. Marital status and attitudes

- a. *Are you married or living with someone? If yes, How do you feel about your marriage (or relationship)?*
- b. *Have you been married (or lived with someone) before? If yes, How many times? What caused the marriage(s) (or relationship(s)) to end?*
- c. *What are the things you like about being married (or living with someone)? Dislike?*
- d. *What do you feel is the most important factor that holds a marriage (or relationship) together? e.g., love, good sex, getting along well, similarities in taste or temperament, social influences, etc.*

F. Has the client ever belonged to social or institutional groups?

1. Membership in special groups

Have you ever belonged to —

- a. *church groups,*
- b. *community groups,*
- c. *school groups (extra-curricular activities),*
- d. *street gangs or social clubs,*
- e. *political groups,*
- f. *sports clubs,*
- g. *military groups,*
- h. *therapy groups?*

If yes for any one or more of the above, inquire about:

2. Membership status
 - a. *How long did you belong to that group?*
 - b. *How often did you attend meetings or get-togethers?*
3. Role in group, i.e., leader or follower
 - a. *Where did you fit into the group?*
 - b. *What did you do?*
4. Extent of group involvement
 - a. *Did you work cooperatively with others toward a group goal?*
 - b. *Did you pursue your own interests with little interest in activities of other group members?*
5. General attitudes toward group affiliations

Do you prefer to spend most of your free time alone, with one other person, or in a group?

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**CONTENT AREA 3:
RATIONALITY QUESTIONS**

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CONTENT AREA 3

III. Rationality

A. Has the client ever demonstrated extreme mood swings?

1. Depression

- a. *You felt really down? What kinds of feelings did you have? helpless, hopeless, depressed?*
- b. *You lost your interest or pleasure in things that you usually enjoy?*
- c. *You lost your ability to concentrate?*
- d. *You felt physically down? fatigue, headaches, digestive disturbances, etc.*

2. Mania

- a. *You felt really hyped up — as if your mind or body were speeding?*
- b. *Everything seemed really rosy?*
- c. *You went on binges? eating, spending, sex, gambling*

3. Mixed — Either Depression or Mania

- a. *There were changes in your sex drives or behavior? What kinds of changes?*
- b. *There were marked changes in your eating habits or in your weight? What kind?*
- c. *You had dramatic changes in sleeping patterns? What kinds of changes? inability to fall asleep, early morning awakening, no need for sleep*

NOTE: If the client answers yes to any of the above, also inquire: *How long did it last? Did it get progressively worse? How were you able to stop it? Is this a problem at this time?*

B. Is the client suicidal?

1. *Have you ever thought of harming yourself?*
2. *Have you ever had thoughts of killing yourself?*
3. *Have you feared that you might act on them?*
4. *Are you having those fears now or recently?*
5. *Is this a problem at this time?*

C. How does the client control strong feelings or impulses?

i. Impulse Control

- a. *Can you wait for something or do you have to have it now?*
- b. *Do you often act on the spur of the moment without considering the consequences? Give examples.*

2. Anger

- a. *Do you get angry easily?*
- b. *What kinds of things make you angry?*
- c. *How do you handle your anger?*
- d. *How would I know if you were angry with me?*
- e. *How do you handle frustration?*

3. Driving record

- a. *Do you drive?*
- b. *How often do you drive?*
- c. *What do you do when other drivers make you angry?*
- d. *How many times have you been stopped for a moving violation?*

4. Food

- a. *Have you ever been on a diet?*
- b. *Were you able to stick to it?*

5. Smoking

- a. *Do you smoke? (Did you smoke in the past?)*
- b. *How much do (did) you smoke?*
- c. *Have you ever tried to quit?*
- d. *What methods did you use?*
- e. *What were your reactions?*

6. Money

- a. *How do you handle money?*
- b. *Do you budget?*
- c. *Do you like to gamble?*

7. Savings

- a. *If you had a three-day supply of drugs, how long could you make it last?*
- b. *How do you plan ahead?*
- c. *When you want something badly, are you able to save up for it?*

D. Does the client have a potential for violence?

1. Violence potential

- a. *Have you ever harmed anyone? If yes, Who was it? What were the circumstances?*
- b. *Was it when you were drug free?*
- c. *Under the influence of drugs?*
- d. *Would you do it again under similar circumstances? Why or why not?*

2. Motivation

- a. *Was it survival or self-defense?*
- b. *Revenge? (NOTE: Take into consideration data from arrest record if appropriate.)*

E. Overall assessment of client's behavior. (See Behavioral Assessment Inventory, next page)

BEHAVIORAL ASSESSMENT INVENTORY

To be completed by counselor after the assessment interviews

Part I: Counselor Observation of the Client's Interview Behavior

	Yes	No	
1. Behavior:			
☐	☐	☐	Is he friendly?
☐	☐	☐	Is he stoned, high, or intoxicated?
☐	☐	☐	Is he unusual or different from most clients you have seen?
☐	☐	☐	Is he hyper?
☐	☐	☐	Is he inactive?
☐	☐	☐	Is he alert?
☐	☐	☐	Does he initiate conversation?
☐	☐	☐	Do you believe him? (Is he credible?)
☐	☐	☐	Is he nervous?
☐	☐	☐	Does he fidget?
☐	☐	☐	Does he sweat?
☐	☐	☐	Is he manipulative?
☐	☐	☐	Is he seductive?
☐	☐	☐	Does he direct the interview?
☐	☐	☐	Is he evasive?
☐	☐	☐	Is he suspicious?
☐	☐	☐	Is he cooperative?
2. Thought Disorder:			
☐	☐	☐	Does he make sense?
☐	☐	☐	Is he thinking straight (or rationally)?
☐	☐	☐	Can you follow him?
☐	☐	☐	Does his attention wander?
☐	☐	☐	Does he answer questions appropriately?
☐	☐	☐	Is the client scared?
3. Sensorium: Does the client know:*			
☐	☐	☐	time? <i>year, month, day of month, day of week</i>
☐	☐	☐	place? <i>geographic location</i>
☐	☐	☐	person? <i>his own name</i>
☐	☐	☐	situation? <i>the interview or clinic</i>
☐	☐	☐	Is his memory okay? <i>recent, remote, recall</i>

* If all, or almost all, answers to the above are "No," further psychological evaluation may be indicated.

Part II: Counselor's Impression of the Client

___ ___ Did you like the client?

___ ___ Does he scare you?

___ ___ Is he a hustler?

___ ___ Is he a nice person?

Does he answer questions superficially or are his answers substantive? *Circle your impression.*

What can you expect of the client?

Other general impressions:

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CONTENT AREA 4:
RESOURCES QUESTIONS

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CONTENT AREA 4

IV. Resources

A. Is the client employed?

1. Nature of the current job (if employed)
 - a. *What kind of work do you do?*
 - b. *How long have you been there?*
 - c. *Do you see yourself staying with this job?*
 - d. *Do you like your co-workers?*
 - e. *Do you see opportunity for advancement?*
2. Previous job history (if any)
 - a. *What kind of work did you do before this?*
 - b. *How long did you work at that job?*
 - c. *Why did you leave?*
 - d. *What did you like about the work there? Dislike?*
3. Nature of work while in jail, military, or similar situations (if appropriate). *Ask questions similar to those in #2 above.*

B. What kind of job skills does the client have?

1. Previous training
 - a. *What kind of training have you had?*
 - b. *Where was training received? jail, military, vocational program, other*
 - c. *What did you learn?*
2. Avocational skills and interests
 - a. *When you were a kid, what kinds of things were you into?*
 - b. *When you were a kid, did you have any hobbies? Do you have any now?*
 - c. *What do you like to do?*
 - d. *What kinds of things would you like to be able to do?*
3. Attitudes toward work
 - a. *If you could write your own ticket, what kind of job would you like to have?*
 - b. *What time of day do you work best?*
 - c. *Whom do you know who has a good job? Why is it good?*

C. Does the client have job-related competencies?

1. Hustling behavior

- a. *Before you came into treatment, how were you raising money for your drugs?* (Straightforward and detailed probing may be required. If the client is evasive, focus on a particular day to serve as an example.)
- b. *Where were you involved in the distribution system?*
- c. *What was your source of drugs?*

2. Implications of the client's status and income change as a result of entering treatment

- a. *How will your entering treatment affect your income or the way you earn a living?*
- b. *Will entering treatment affect your status in any other way?*

D. How does the client spend his leisure time, relax, have fun?

1. Current activities

- a. *Other than drugs, what do you do with your free time?*
- b. *Given that you won't have much money, how would you like to spend your time enjoying yourself?*
- c. *Do you know how you might go about pursuing these interests?*
- d. *Do you know of any places that you might pursue these interests?*

2. Relationships with non-drug-abusing individuals

- a. *How do you feel about straight people?* (people who do not abuse drugs)
- b. *Is it difficult for you to talk with these people?*
- c. *Do you have many straight friends?*
- d. *Do you know any places where straight people hang out?*
- e. *Do you ever go there? If yes, How do you feel about going there?*

E. Where does the client live? With whom?

1. Duration of current residence

- a. *Where do you live?*
- b. *With whom do you live?*
- c. *How long have you lived there?*

2. Risks involving current housing

- a. *Does your spouse or roommate use drugs?*
- b. *If yes, How do they feel about your trying to kick?*
- c. *What things at home make it hard or easy for you to kick?*

3. Satisfaction with or plans to change current housing
 - a. *What do you like about your present living conditions? Dislike?*
 - b. *Is it dangerous staying where you are presently living? In what way?*
 - c. *What is preventing you from making a change?*
 4. Previous residences
 - a. *Where did you live before this?*
 - b. *How long did you live there?*
 - c. *What has been the longest period of time you lived in any one place?*
 - d. *Do you move about often to get away from people or problems?*
- F. How far has the client gone in school?**
1. Degrees and certificates

Do you have any diplomas, degrees or certificates from school or any other training?
 2. Academic performance
 - a. *What were your grades like?*
 - b. *How did they compare with other students' grades?*
 - c. *How were they with respect to where you wanted to be?*
 - d. *Could you have done better if you wanted to?*
 3. Attitudes
 - a. *What were your feelings about school?*
 - b. *What were some of the things you liked about school? Disliked?*
 4. Special interests
 - a. *Were there any subjects that you really liked?*
 - b. *Were there any subjects in which you got good grades?*
 - c. *Were there any teachers who really turned you on or encouraged you?*
 5. Interest in continuing education
 - a. *Have you ever thought of finishing high school (college) or getting your GED (degree)?*
 - b. *How important do you feel education is to you?*
 - c. *How do you feel about the educational system in general?*
 6. Self-education
 - a. *Do you ever read books or magazines?*
 - b. *If yes, Tell me about something you've read recently or the kinds of things you'd like to read if you had the chance.*
 - c. *Do you take any special interest courses? e.g., adult education courses, community sports or crafts courses, computer, secretarial, etc.*

G. Does the client have any medical, dental, hygienic, or nutritional problems that require attention?

1. Medical or dental problems

Do you have any medical or dental problems that need immediate attention?

2. Nutrition

- a. *How many meals do you usually eat each day?*
- b. *Do you eat breakfast? If applicable, Do your children have breakfast before going to school?*
- c. *What do your children do about lunch at school? buy, take Do they have break, st and lunch every day?*
- d. *What kinds of foods do you generally eat for your main meals?*
- e. *Do you feel that you and children, if applicable are getting enough to eat?*
- f. *Do you receive any food assistance benefits? e.g., surplus commodities, food stamps, donated foods, free school lunches*

3. Children's health (if applicable)

- a. *Are your children in good health?*
- b. *Who is responsible for their medical care? (Specify clinic or private physician.)*
- c. *What vaccinations have they received? When?*
- d. *Any serious illnesses or hospitalizations ever for any of the children?*
- e. *Are you concerned about any unusual behavior in your children? bed-wetting, nightmares, hyperactivity, etc.*
- f. *Do you ever give drugs to any of your children for special problems such as sleeplessness, nervousness, or hyperactivity?*
- g. *Where do you keep your methadone or other drugs in the house? Are they in a child-proof place?*

Except for question 4 (which also applies to men), the following sections contain questions pertaining to female clients. You are not trying to take a gynecological history here, but simply trying to assess whether or not a medical referral or some basic education is needed.

4. Contraception and gynecological care: knowledge of available techniques — oral contraception, foam, IUD, rhythm method, sterilization of self or spouse

- a. *What kind of birth control do you use, if any?*
- b. *Who takes responsibility for contraception?*
- c. *When was your last Pap smear? Pelvic examination? What were the results?*
- d. *Have you ever been treated for pelvic infection? If yes, Which?*
- e. *Other physical-sexual problems? Specify: venereal diseases, trichomoniasis, fungus infection, urinary problems, painful intercourse, unusual discharge.*

5. Pregnancies and abortions

- a. *How many pregnancies have you had? Were there any miscarriages or delivery problems? Caesarean, etc.*
- b. *Have you ever had any abortions? What kind? Did you have any medical after-effects?*
- c. *What were your feelings about having the abortion? if applicable*
- d. *Are you pregnant now? If yes, Are you receiving proper medical care? From whom or where? If not under physician's care, make plans for immediate referral.*

6. Menstrual health

- a. *Do you have regular menstrual periods?*
- b. *Are periods different when you are on or off various drugs?*
- c. *Do you experience any difficulties (pain, excessive bleeding) with your periods? Is there a difference when you are on or off drugs?*

H. Does the client have a regular source of income?

1. Source of income (if not covered in employment section)

2. Sufficiency of income

Is your income sufficient to meet your living needs?

3. Money management

- a. *Do you have any money in reserve?*
- b. *Can you hold onto money when you get it or do you spend it right away?*
- c. *Do you have a bank account?*
- d. *Where does most of your money go?*
- e. *Do you like to gamble or play the numbers?*
- f. *Where do you get your checks cashed?*

4. Credit purchases (focus on whether the client loses money because of poor consumer practices)

Do you tend to pay for things right away, or do you take time payments?

5. Debt management (the extent of indebtedness and the client's credit rating)

- a. *How do you handle your debts and bills?*
- b. *What do you think your credit rating is like?*

6. Bonding for security jobs

- a. *Do you have any interest in security jobs that would require bonding?*
- b. *Do you think you would have any difficulty getting bonded for security jobs?*

I. What is the client's means of transportation?

1. Means of transportation (own transportation, reliance on others, use of public transportation)
2. Possession of driver's license; availability of car
3. Knowledge of mass transit system
4. Anxiety related to mass transit
5. Distances involved: distances client lives from work, stores, treatment center, etc.

J. Does client have current or pending legal problem (criminal or civil)?

1. Current arrests, suits, or other pending litigations
2. Divorce or alimony problems
3. Tenant or consumer difficulties

K. Does the client have relationships with other agencies?

1. Assistance from other social service agencies (current or past)

Have you ever received assistance from —

- a. *welfare agencies* (AFDC, food stamps, etc.);
- b. *Vocational Rehabilitation*;
- c. *Employment Security Commission*;
- d. *Veterans Administration* (hospital or outpatient service);
- e. *community health services* (dental clinics, free health clinics, etc.);
- f. *probate court*;
- g. *insurance policies* (for medical, psychological, dental);
- h. *other services*?

2. Eligibility for assistance

Do you know if you are eligible for assistance from any third party payors such as the above?*

- * This may need rephrasing in terms the client can understand.

INTAKE INFORMATION SUMMARY

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Handout

SAMPLE DRAFT FOR AITP

INTAKE INFORMATION SUMMARY

Client: Pam Date: 9/6/75

Client No: _____

Address: 1901 North Moore St., #7, Rosslyn, Virginia 90010

Phone: 524-3400 Birth Date: 8/4/53

Marital Status: Single, never married

Dependents: 1 daughter, age 3, named Christine, born 6/2/72

Employment: None

Drug of Choice: Heroin

Length of Use: 5 years

Other Drug Use: barbiturates, cocaine, illicit methadone

No medical problems

PO: *Mr. Richard Jones*
Arlington County Parole & Probation
(703) 524-5903

INTERVIEW NOTES

Date: 9/12/75

Notes: On time for interview. Sent by PO — condition of probation. Involuntary. Busted for possession of H. Claims police stopped her for traffic violation and found in possession (traveling alone). Would not have sought treatment unless busted. No previous arrests. Wants "to get off drugs" and get off probation. Doesn't see methadone treatment as being on drugs. Can't state any other goals. Sees treatment as getting methadone. Has been in treatment two times before. "Treatment" consisted of getting help from friends and self-help. First attempt to quit was three years ago when pregnant — "Tried to get off for the kid." Second attempt 1½ years ago. Best effort was one month. Three year old daughter "real neat." Friends who have been in programs sometimes talked about "convenience" of having reliable methadone. Parents shocked about bust and drug use. Told parents she wasn't using. Hinted that mother was glad Pam was getting into program because mother thinks Pam has "problems." Boyfriend said program better than jail. Not much other info from session. Client not very open. Spent some time discussing purpose of interview and expectations.

Date: 9/17/75

Notes: Pam oldest child; three brothers ages 20, 18, 15; one sister age 17. Moved out of parents' home less than one year ago. Claims happy childhood, vacations, but didn't offer any other detail. Says has comfortable, close talks with mother, and tolerates yelling father. About this point in the interview I began to think Pam was painting a prettier picture of her family than was really there. Parents got divorced and remarried again when Pam was about 16. Described mother as quiet (tolerant?). Suspected father was messing around. Parents had angry fight. Avoids father and his anger. Mother presently working; she worked sporadically in past when father got laid off. Pam was in high school then. Was getting hassled by parents about how she was raising her kid; moved out to live with present boyfriend and left daughter behind. Wishes she'd left earlier. Lives close — either talks to mother or visits parents' home frequently. Parents don't like boyfriend and blame him for her leaving home. Boyfriend thinks Pam should be out of the house and thinks the daughter should stay with the parents. Boyfriend not father of child. Lost contact with child's father soon after he discovered Pam was pregnant. Pam's mother supportive during pregnancy. Pam thinks groups are stupid, but she seems to like the attention of group. Example: She told a story about being voted most popular girl in her school. Proud of how she gets along with men; says other women are usually jealous of her. Likes living with boyfriend but thinks marriage would tie her down. Says they have a good relationship. Living with him better than living at home. She's had many boyfriends. This is the longest relationship she has sustained. Says this one is the best because he has money. I get the feeling he might be dealing. No close girlfriends. I'm beginning to wonder about relationship with family; it seems that Pam uses them, especially mother. Wonder why she is so closed — maybe hurt badly in past, but can't tell if family-related or pregnancy-related or something else.

Date: 9/19/75

Notes: Mother called expressing concern about Pam. Wants to know if she'll be getting help solving her problems. I simply explained program and confidentiality and encouraged her and Pam to talk.

Date: 9/23/75

Notes: Doesn't appear to be in touch with feelings. Didn't want to talk about being depressed. Hollow laughter when I asked question. Handles depression by sleeping. Periods of depression sound chronic but not severe — just global or general. Can't tell when she's not depressed. Doesn't connect depression with drug use. Doesn't like to express anger either. She says that she handles other people's anger by remaining silent and not provoking other person, sometimes just splits. Does not appear to deal with her own anger very constructively. Attitude toward relationships: "Either you get them or they get you." I think she's trying to avoid being "got" by me. Other than this, there do not appear to be any indications of psychosis or other pathologies. (See Behavior Assessment Inventory.) She also does not seem to be a candidate for suicide. I get the impression that Pam is pretty street-wise and has good survival skills but still having some difficulty getting her to open up and share much about herself. I told Pam that mother had called. Pam said she knew about this. Discussed briefly mother's concern. Pam said it's none of her business. Pam later said it was all right if I talked to mother if mother called, but I shouldn't call her mother. Beginning to get impression that there are some inconsistencies in Pam's story. Had her sign disclosure release to OK talking to her mother.

Date: 9/30/75

Notes: Claims to like dealing with people. Attended cosmetology school. Found out that she didn't like being a beautician after leaving school. It wasn't really dealing with people. Got impression that by dealing with people means she likes to manipulate to get what she wants. Liked history in high school because of men teachers. Other interests include men, buying clothes. She says that some of her clothes are presents from her boyfriend. During leisure time she likes watching TV, especially the soap operas. That is between trying to find a decent job for herself. She parties or gets together with a few of her boyfriend's friends infrequently. She thinks that if she can get some help through the program, that she would like to travel. Other than some cosmetology training, Pam has not had any other type of vocational training. Not much work experience. Identifying some prevocational or vocational skills or training may be difficult with Pam at this point. Pam seems to talk about weaknesses much more easily than strengths — negative self-concept. Seems to be pretty impulsive. Doesn't think through what she is doing or planning to do. Sets self up for failure(?).

Date: 10/4/75

Notes: Another telephone call from mother. Mother said that Pam may have been upset about my asking about her school background. Mother claimed that Pam had not graduated from high school nor had she gone to cosmetology school, but had assisted in a friend's beauty shop and thus does have some interest in that area. Have I been had? Getting the impression that mother had protected and spoiled Pam. Mother seems to see Pam as the darling daughter and naturally "wants the best for her since Pam is capable of so much more than what she has now."

Date: 10/8/75

Notes: Next scheduled interview is two weeks from now. Will begin drafting case history for tentative treatment planning.

BEHAVIORAL ASSESSMENT INVENTORY

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BEHAVIORAL ASSESSMENT INVENTORY

To be completed by counselor after the assessment interviews

Part I: Counselor Observation of the Client's Interview Behavior

- | | Yes | No | |
|-------------------------------------|-----|-----|---|
| 1. Behavior: | | | |
| | ___ | ___ | Is he friendly? |
| | ___ | ___ | Is he stoned, high, or intoxicated? |
| | ___ | ___ | Is he unusual or different from most clients you have seen? |
| | ___ | ___ | Is he hyper? |
| | ___ | ___ | Is he inactive? |
| | ___ | ___ | Is he alert? |
| | ___ | ___ | Does he initiate conversation? |
| | ___ | ___ | Do you believe him? (Is he credible?) |
| | ___ | ___ | Is he nervous? |
| | ___ | ___ | Does he fidget? |
| | ___ | ___ | Does he swear? |
| | ___ | ___ | Is he manipulative? |
| | ___ | ___ | Is he seductive? |
| | ___ | ___ | Does he direct the interview? |
| | ___ | ___ | Is he evasive? |
| | ___ | ___ | Is he suspicious? |
| | ___ | ___ | Is he cooperative? |
| 2. Thought Disorder: | | | |
| | ___ | ___ | Does he make sense? |
| | ___ | ___ | Is he thinking straight (or rationally)? |
| | ___ | ___ | Can you follow him? |
| | ___ | ___ | Does his attention wander? |
| | ___ | ___ | Does he answer questions appropriately? |
| | ___ | ___ | Is the client scared? |
| 3. Sensorium: Does the client know: | | | |
| | ___ | ___ | time? <i>year, month, day of month, day of week</i> |
| | ___ | ___ | place? <i>geographic location</i> |
| | ___ | ___ | person? <i>his own name</i> |
| | ___ | ___ | situation? <i>the interview or clinic</i> |
| | ___ | ___ | Is his memory okay? <i>recent, remote, recall</i> |

If all, or almost all answers to the above are "No," further psychological evaluation may be indicated.

Part II: Counselor's Impression of the Client

- ___ ___ Did you like the client?
___ ___ Does he scare you?
___ ___ Is he a hustler?
___ ___ Is he a nice person?
 Does he answer questions superficially or are his answers substantive? *Circle your impression.*

What can you expect of the client?

Other general impressions:

CASE HISTORY OUTLINE

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Sample Draft for AITP
CASE HISTORY OUTLINE

Counselor (Interviewer's) Name _____ Date _____

I. Identifying Data

Client's Name _____ Client No. _____

Alias(es) or Nicknames _____

Home Address _____

City _____ State _____ Zip Code _____

Phone _____

Date of Birth _____ Age _____ Sex _____

Ethnicity _____ Marital Status _____

Dependents _____ Relationship _____

Current Employment _____

II. Readiness

Facts:

OUTLINE PAGE 2

Impressions:

III. Relationships

Facts:

OUTLINE PAGE 3

Impressions:

IV. Rationality

Facts (also see Behavioral Assessment Inventory):

OUTLINE PAGE 4

Impressions:

V. Resources

Facts:

OUTLINE PAGE 5

Impressions:

VI. Summary

OUTLINE PAGE 6

Other Impressions:

VII. Information Attached: Behavioral Assessment Inventory (Medical Record, Psychological Record, Academic Record, etc.)

TREATMENT PLANNING GUIDE

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Date of next review: _____

Counselor: _____

TREATMENT PLANNING GUIDE

Client's Name: _____ Date: _____

Client Number: _____ AITP Counselor: _____

Assigned Counselor: _____

I. Treatment:

Current treatment modality: _____

Medication: _____ Dosage: _____

Type and frequency of counseling: _____

Other supportive services and activities (frequency of each):

Definitions

Goals: The aims, purposes, or end products to be accomplished as a result of treatment, based upon the client needs and the program services

Tasks: The activities, actions, behaviors or steps the *client* must do or take in order to reach the goal. These are objective and observable, and become the basis upon which progress notes are written

II. Long-term Goals:

III. Short-term Goals (90 days or less):

Goals	Tasks

Comments (rationale for plan):

Note: NIDA Federal funding criteria require that outpatient programs review treatment plans at least once every 90 days. All other modalities (day-care and residential programs) must review at least once every 30 days.

TUESDAY, JULY 1, 1975

WASHINGTON, D.C.

Volume 40 ■ Number 127

PART IV



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

■

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

General Provisions

Reprinted by

U.S. Department of Health, Education, and Welfare
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
National Institute on Drug Abuse

RULES AND REGULATIONS

Title 42—Public Health
CHAPTER 1—PUBLIC HEALTH SERVICE,
DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

SUBCHAPTER A—GENERAL PROVISIONS
PART 2—CONFIDENTIALITY OF ALCOHOL
AND DRUG ABUSE PATIENT RECORDS

On May 9, 1975, the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention published in the *FEDERAL REGISTER* (40 FR 20522) a notice of proposed joint rulemaking setting forth a proposed new Part 2 of Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records.

Interested persons were invited to submit written comments, views, or arguments with respect to the proposed regulations within 30 days of the date of publication of that notice. All comments so submitted were carefully considered, and at various stages in the rulemaking process, the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected by the proposed regulations were consulted.

As finally adopted and set forth hereinafter, the regulations contain two major substantive changes from the May 9 proposal. The separate treatment of funding sources and third-party payers (§§ 2.21 and 2.37 of the proposed regulations) was abandoned as unworkable, primarily because the prohibitions which the proposed regulations would have placed on funding sources would have directly conflicted with requirements which have been proposed in implementation of Title XX of the Social Security Act (see proposed 45 CFR 228.63, 40 FR 16802, 16809, April 14, 1975). In lieu of this approach, § 2.37 has been revised to provide that funding sources and third-party payers maintaining drug or alcohol abuse patient records are subject to restrictions upon disclosure to the same extent and in the same manner as any other entity maintaining records which are within the scope of the authorizing legislation and this Part.

The other major change is in the area of criminal justice system referrals, and the grounds for the rules finally adopted are set forth in the basis and purpose section (§ 2.39-1) pertaining thereto. In connection with that change, it must be frankly acknowledged that the arguments set forth in the corresponding basis and purpose section (§ 2.40-1) of the May 9 proposal have merit. The final rule may in certain instances result in a compromise of the treatment process, if judges or other authorities in the criminal justice system overreact to information whose communication is allowed under the final rules but would have been prohibited under the proposed rules.

Against such an adverse effect, however, there must be weighed the very real advantage which genuine cooperation between community social service systems and the criminal justice system can yield for those whose lives are crippled and scarred by the consequences of their own

criminal conduct. Governmental responses based on a pure medical model have not met with noticeably greater success than those based on a purely punitive approach, and it would be tragic if these rules were so constructed as to become a barrier to the development of better ways to deal with those who are caught up in a pattern of seriously antisocial behavior.

In addition to the foregoing major changes, the following minor policy changes were made.

Provisions relating to destruction or other disposition of records were dropped from § 2.21 (§ 2.22 in the May 9 proposal) as unnecessary except in the case of programs discontinuing operations.

The fixed limitation on the permissible duration of written consent for disclosure was dropped from § 2.31 in favor of a limitation to such duration as may be reasonably necessary to effectuate the purpose for which the consent is given.

The specification of crimes in § 2.65 for which a court order may be granted authorizing use of program records in the investigation or prosecution of a patient was broadened to cover any "extremely serious" crime, with those listed in the May 9 notice being retained as examples.

Finally, a number of clarifying, technical, and conforming changes were made in the May 9 proposal, but these are without significant substantive effect.

Accordingly, pursuant to the authority of section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended by Pub. L. 92-282 (21 U.S.C. 1175), and section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended by Pub. L. 93-282 (42 U.S.C. 4582), and under the authority delegated to the General Counsel of the Special Action Office for Drug Abuse Prevention (39 FR 17901, May 21, 1974), Subchapter A of Chapter I, Title 42, Code of Federal Regulations, is amended by inserting immediately after Part 1 thereof a new Part 2 to read as set forth below.

Effective date. These regulations shall be effective on August 1, 1975.

Dated: June 25, 1975.

R. MOURE,
Acting Assistant Secretary for
Health, Department of
Health, Education, and Wel-
fare.

Approved: June 26, 1975.

CASPAR W. WEINBERGER,
Secretary of Health, Education,
and Welfare.

Dated: June 27, 1975.

GRASTY CREWS II,
General Counsel, Special Action
Office for Drug Abuse Preven-
tion.

Dated: June 27, 1975.

ROBERT L. DUPONT,
Director, Special Action Office
for Drug Abuse Prevention.

Subpart A—Introductory Statement

- Sec. 2.1 Statutory authority—drug abuse.
- 2.2 Statutory authority—alcohol abuse.
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- 2.4 General purposes.
- 2.5 Format.
- 2.6 Administration and enforcement in general.
- 2.7 Reports of violations.

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- 2.12 Applicability—rules.
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- 2.14 Penalty for violations—rules.
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- 2.15 Minor patients—rules.
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- 2.16 Incompetent and deceased patients—rules.
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- 2.18 Extent of disclosure—rules.
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- 2.19 Undercover agents and informants—rules.
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- 2.24 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act—rules.
- 2.24-1 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act—basis and purpose.

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- 2.31 Written consent required—rules.
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- 2.32 Prohibition on redisclosure—rules.
- 2.32-1 Prohibition on redisclosure—basis and purpose.
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- 2.34 Prevention of certain multiple enrollments—rules.
- 2.34-1 Prevention of certain multiple enrollments—basis and purpose.
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- 2.35-1 Legal counsel for patient—basis and purpose.
- 2.36 Patient's family and others—rules.
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- 2.37 Third party payers and funding sources—rules.
- 2.37-1 Third party payers and funding sources—basis and purpose.

- Sec.**
- 2.38** Employers and employment agencies—rules.
- 2.38-1** Employers and employment agencies—basis and purpose.
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- 2.39-1** Criminal justice system referrals and functions—basis and purpose.
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- 2.52** Research, audit, and evaluation—rules.
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- 2.64** Procedures and criteria in general—rules.
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- 2.66** Investigation and prosecution of programs—rules.
- 2.66-1** Investigation and prosecution of programs—basis and purpose.
- 2.67** Undercover agents and informants—rules.
- 2.67-1** Undercover agents and informants—basis and purpose.

Subpart A—Introductory Statement

§ 2.1 Statutory authority—drug abuse.

(a) *Statutory provisions effective May 14, 1974.* Insofar as the provisions of this part pertain to any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research, such provisions are authorized under section 408 of Pub. L. 92-255, the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) as amended by section 303 of Pub. L. 93-282 (88 Stat. 137). That section reads as follows:

§ 408. Confidentiality of patient records.

(a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (c), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) (1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b) (2) (C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(g) The Director of the Special Action Office for Drug Abuse Prevention, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b) (2) (C), as in the judgment of the Director are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(b) *Amendments effective June 30, 1975.* Effective on the date specified in section 104 of the Drug Abuse Office and Treatment Act of 1972 (June 30, 1975), the first sentence of section 408(g) above, will be amended by striking "Director of the Special Action Office for Drug Abuse Prevention" and inserting in lieu thereof "Secretary of Health, Education, and Welfare", and the second sentence of such section will be amended by striking "Director" and inserting "Secretary" in lieu thereof. Also effective on that date, section 408, above, will be further amended by (1) striking out "The" and inserting in lieu thereof "Except as provided in subsection (h) of this section, the" in the first sentence of subsection (g) of such section; and (2) adding at the end of such section the following new subsection:

(h) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations established by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from drug abuse. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

§ 2.2 Statutory authority—alcohol abuse.

Insofar as the provisions of this part pertain to any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, such provisions are authorized under section 333 of Pub. L. 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582), as amended by section 122(a) of Pub. L. 93-282, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (88 Stat. 131). As so amended, that section reads as follows:

CONFIDENTIALITY OF RECORDS

Sec. 333. (a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) (1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(g) Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(h) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations prescribed by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from alcohol abuse or alcoholism. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

§ 2.3 Previous regulations as controlling authority.

Attention is called to the interpretative regulations, issued by the Special Action Office for Drug Abuse Prevention (37 FR 24636, November 17, 1972, as revised 38 FR 33744, December 6, 1973, referred to hereinafter in this part as the "previous regulations"). Those regulations have been given a special status as controlling authority by the provisions of section 303(d) of Pub. L. 93-282, as well as the references in the legislative history of that act to the precedents established under section 408 of Pub. L. 92-255. Such references appear at page 11 of House Committee Report No. 93-759 and at page H3563 of the Congressional Record for May 6, 1974. The latter citation is to a detailed analysis of the bill in its final form which was submitted for the Record by its floor manager, Chairman Staggers of the Interstate and Foreign Commerce Committee, when the bill was up for final action by the House of Representatives.

§ 2.4 General purposes.

(a) *Policy objectives.* The purpose of the regulations set forth in this part is to implement the authorizing legislation in a manner that, to the extent practicable, takes into account two streams of legal thought and social policy. One has to do with enhancing the quality and attractiveness of treatment systems. The other is concerned with the interests of patients as citizens, most particularly in regard to protecting their rights of privacy. Within each stream there are cross-currents, and it should come as no surprise that areas of turbulence are to be found at their confluence.

(b) *Limited purpose.* The regulations contained in this part are not intended to direct the manner in which substantive functions, such as research, treatment, and evaluation, should be carried out, but rather to define the minimum requirements for the protection of confidentiality of patient records which must be satisfied in connection with the conduct of those functions in order to carry out the purposes of the authorizing legislation. This does not mean that observance of only the minimum legal requirements is always the wisest course, but in framing these regulations, allowance has necessarily been made for a diversity of emphasis and approach in the many different jurisdictions and by the great variety of public and private agencies which must find a way to function within the limits here prescribed.

§ 2.5 Format.

(a) *Basis and purpose sections.* Each section setting forth rules on any given topic in Subparts B through E of this part is followed by a section setting forth their basis and purpose. In many cases, the basis and purpose section is itself an interpretative rule regarding the legal authority of the rulemakers. In other instances, it summarizes historical or

evidentiary material relevant to the validity and interpretation of the section which precedes it.

(b) *Statutory rules fully incorporated.* Although, for convenience of reference, the statutory basis for this part is set out in full in §§ 2.1 and 2.2, the regulations in Subparts B through E of this part are intended to include all of the operative statutory provisions.

§ 2.6 Administration and enforcement in general.

It is not contemplated that any particular agency will be set up specifically to enforce compliance with this part. Programs which receive Federal grants may be monitored for compliance with this and other applicable Federal law as an incident to the grant administration process. Similarly, FDA inspections of methadone programs will include inspection for compliance with this part, which is incorporated by reference in the methadone regulation (21 CFR 310.505).

§ 2.7 Reports of violations.

Any violation may be reported to the United States Attorney for the judicial district in which the violation occurs. Violations on the part of methadone programs may be reported to the regional offices of the Food and Drug Administration. Violations on the part of a Federal grantee or contractor may be reported to the Federal agency monitoring the grant or contract.

Subpart B—General Provisions

§ 2.11 Definitions and usages.—Rules.

(a) *Authorizing legislation.* The term "authorizing legislation" means section 408 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) and section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582), as such sections may be amended and in effect from time to time.

(b) *Construction of terms.* The definitions and rules of construction set forth in this section are applicable for the purposes of this part. To the extent that they refer to terms used in the authorizing legislation, they are also applicable for the purposes of such legislation.

(c) *Alcohol abuse.* The term "alcohol abuse" includes alcoholism.

(d) *Drug abuse.* The term "drug abuse" includes drug addiction.

(e) *Diagnosis and treatment.* The terms "diagnosis" and "treatment" include interviewing, counselling, and any other services or activities carried on for the purpose of or as an incident to diagnosis, treatment, or rehabilitation with respect to drug abuse or alcohol abuse, whether or not conducted by a member of the medical profession.

(f) Program.

(1) The term "program", when referring to an individual or organization, means either an individual or an organization furnishing diagnosis, treatment, or referral for alcohol abuse or drug abuse.

(2) The term "program", when not used in the sense defined in paragraph (f)(1), means a plan or procedure, whether functional or organizational, and whether or not governmental, for dealing with alcohol abuse or drug abuse problems from either an individual or a social standpoint.

(g) *Program evaluation.*

The term "program evaluation" means an evaluation of—

(1) The effectiveness, efficiency, compliance with applicable therapeutic, legal, or other standards, or other aspects of the performance, of a program as defined in paragraph (f)(1) of this section, or

(2) The validity, effectiveness, efficiency, practicability, or other aspects of the utility or success of a program in the sense defined in paragraph (f)(2) of this section.

(h) *Program director.* The term "program director" in the case of a program which is an individual means that individual, and in the case of a program which is an organization, the individual, if any, who is the principal, or, in the case of organizations consisting of partners or under the control of a board of directors, board of trustees or other governing body, the individual designated as program director, managing director, or otherwise vested with executive authority with respect to the organization.

(i) *Patient.* The term "patient" means any individual (whether referred to as a patient, client, or otherwise) who has applied for or been given diagnosis or treatment for drug abuse or alcohol abuse and includes any individual who, after arrest on a criminal charge, is interviewed and/or tested in connection with drug or alcohol abuse preliminary to a determination as to eligibility to participate in a treatment or rehabilitation program.

(j) *Patient identifying information.* The term "patient identifying information" means the name, address, social security number, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a patient identifying number assigned by a program.

(k) *Alcohol abuse or drug abuse prevention function.* The term "alcohol abuse or drug abuse prevention function" means any program or activity relating to alcohol abuse or drug abuse education, training, treatment, rehabilitation, or research, and includes any such function even when performed by an organization whose primary mission is in the field of law enforcement or is unrelated to alcohol or drugs.

(l) The term "person" means an individual, a partnership, a corporation, a trust, a Federal or State governmental agency, or any other legally cognizable entity.

(m) *Service organization.* The term "service organization" means a program which provides services to a program such as data processing, dosage prepara-

tion, laboratory analyses, or legal, medical, accounting, or other professional services.

(n) *Qualified service organization.* The term "qualified service organization" means a service organization which has entered into a written agreement with a program pursuant to which the service organization—

(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the program about patients in the program, it is fully bound by the provisions of this part;

(2) undertakes to institute appropriate procedures for safeguarding such information, with particular reference to patient identifying information; and

(3) undertakes to resist in judicial proceedings any efforts to obtain access to information pertaining to patients otherwise than as expressly provided for in this part.

(o) *Records.* The term "records" includes any information, whether recorded or not, relating to a patient, received or acquired in connection with the performance of any alcohol abuse or drug abuse prevention function, whether such receipt or acquisition is by a program, a qualified service organization, or any other person.

(p) *Communications not constituting disclosure.* The following types of communications do not constitute disclosures of records:

(1) Communications of information within a program between or among personnel having a need for such information in connection with their duties.

(2) Communications between a program and a qualified service organization of information needed by the organization to perform its services to the program.

(3) Communications of information which includes neither patient identifying information nor identifying numbers assigned by the program to patients.

(q) *Previous regulations.* The term "previous regulations" refers to the interpretative regulations issued by the Special Action Office for Drug Abuse Prevention, originally published November 17, 1972, 37 FR 24636, as revised December 6, 1973, 38 FR 33744.

(r) *State law.* The term "State law" refers to the law of a State or other jurisdiction, such as the District of Columbia, as distinguished from Federal law in general. As applied to transactions which do not take place in any State or other similar jurisdiction, the term refers to Federal common law as modified by any applicable Federal statutes and regulations.

(s) *Third party payer.* The term "third party payer" means any organization (or person acting as agent or trustee for an organization or fund) which pays or agrees to pay for diagnosis or treatment furnished or to be furnished to a particular individual, where such payment or agreement to pay is on the basis of an individual relationship between the payer and the patient (or a member of the patient's family in

the case of self-and-family insurance coverage or similar arrangements) evidenced by a contract, an insurance policy, a certificate of membership or participation, or similar documentation.

(t) *Funding source.* The term "funding source" means any individual or any public or private organization, including any Federal, State, or local governmental agency, which makes payments in support of a program. A funding source is not, as such, a third party payer, even where its payment are based directly or indirectly on the program's patient load with or without respect to specified categories of eligible persons.

(u) *August 22, 1974 draft.* References to the "August 22, 1974 draft" are to the draft regulations set out in the Advance Notice of Proposed Joint Rulemaking published in the FEDERAL REGISTER on August 22, 1974, 39 FR 30426, by the Department of Health, Education, and Welfare and the Special Action Office for Drug Abuse Prevention.

§ 2.11-1 Definitions and usages.—Basis and purpose.

(a) *In general.* The definitions are based upon the legislative history of and experience with the authorizing legislation, and are intended as aids to construing the provisions of this part to carry out the purposes of those statutes.

(b) *Coverage of applicants for treatment.* Section 2.11(i) is intended to make it clear that records of the identity and other information about a person whose application is rejected or withdrawn are fully as much covered by this part as records pertaining to a patient actually accepted for treatment.

(c) *Program terminology for patients not controlling.* While many programs prefer to use "client" or some other term instead of "patient" to describe the recipients of their services, it is believed preferable to use terminology in this part which is consistent with that used in the authorizing legislation. It should be clearly understood, however, that the records of any individual who fits the definition set forth in § 2.11(i) are covered, no matter what terminology the program may use to designate his status.

(d) *Origin of "prevention function" terminology.* The definition of alcohol abuse or drug abuse prevention function in § 2.11(k) is adapted from the definition of drug abuse prevention function in section 103(b) of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1103(b)). Although there was no corresponding defined term available to the draftsman of the 1974 amendment to section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582), it is clear from the legislative history that the coverage of alcohol abuse patient records was intended to be fully as wide as the coverage of drug abuse patient records, and the definition in § 2.11(k) reflects that intention.

(e) *Ambiguity of the term "program".* It is recognized that it is ordinarily poor drafting technique to use the same term

in senses which are as different, yet related, as those in §§ 2.11(f)(1) and 2.11(f)(2). This part, however, has to be read both in conjunction with the Food and Drug Administration's Methadone Regulation and the Drug Abuse Office and Treatment Act of 1972. The Methadone Regulation (21 CFR 310.505) clearly uses the term "program" in the § 2.11(f)(1) sense. In section 103(b) of the Act (21 U.S.C. 1103(b)), it is clearly used in the § 2.11(f)(2) sense, and the usage in section 408(b)(2)(B) of the Act has from its original enactment been administratively interpreted to include both senses. As used in this part, the context should indicate the intended meanings with sufficient clarity to make this preferable to creating and defining new terminology which would be different from that used in related regulations and the authorizing legislation.

(f) *Construction of disclosures.* Section 2.11(p) is intended to clarify the status of communications which are carried on within a program or between a program and persons or organizations which are assisting it in providing patient care. The authorizing legislation was not intended to prohibit programs from carrying on accepted practices in terms of obtaining specialized services from outside organizations. In conjunction with the definition of qualified service organizations, set forth in § 2.11(n), the provisions of § 2.11(p) should prevent the development of abuses in this area.

§ 2.12 Applicability.—Rules.

(a) *In general.* Except as provided in paragraph (b) of this section, this part applies to records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any alcohol abuse or drug abuse prevention function—

(1) Which is conducted in whole or in part, whether directly or by grant, contract, or otherwise, by any department or agency of the United States.

(2) For the lawful conduct of which in whole or part any license, registration, application, or other authorization is required to be granted or approved by any department or agency of the United States.

(3) Which is assisted by funds supplied by any department or agency of the United States, whether directly through a grant, contract, or otherwise, or indirectly by funds supplied to a State or local government unit through the medium of contracts, grants of any description, general or special revenue sharing, or otherwise, or

(4) Which is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program conducting such function, or by a way of a tax-exempt status for such program.

(b) *Armed Forces and Veterans' Administration.*

(1) The provisions of this part do not apply to any interchange, entirely with-

in the Armed Forces, within those components of the Veterans' Administration furnishing health care to veterans, or between such components and the Armed Forces, of records pertaining to a person relating to a period when such person is or was subject to the Uniform Code of Military Justice.

(2) Except as provided in paragraph (b)(1) of this section, this part applies to any communication between any person outside the Armed Forces and any person within the Armed Forces.

(3) Except as provided in paragraph (b)(1) of this section, this part applies, insofar as it pertains to any drug abuse prevention function, to any communication between any person outside those components of the Veterans' Administration furnishing health care to veterans and any person within such components, until such date as the Secretary of Health, Education and Welfare exercises his authority (conferred by an amendment effective June 30, 1975) to prescribe regulations under section 408 of Pub. L. 92-255 (21 U.S.C. 1175). After such date, this part applies thereto to such extent as the Administrator of Veterans' Affairs, through the Chief Medical Director, by regulation makes the provisions of this part applicable thereto.

(4) Except as provided in paragraph (b)(1) of this section, this part applies, insofar as it pertains to any alcohol abuse prevention function, to any communication between any person outside those components of the Veterans' Administration furnishing health care to veterans and any person within such components, to such extent as the Administrator of Veterans' Affairs, through the Chief Medical Director, by regulation makes the provisions of this part applicable thereto.

(c) *Period covered as affecting applicability.* The provisions of this part apply to records of identity, diagnosis, prognosis, or treatment pertaining to any given individual maintained over any period of time which, irrespective of when it begins, does not end before March 21, 1972, in the case of diagnosis or treatment for drug abuse or before May 14, 1974, in the case of diagnosis or treatment for alcohol abuse.

(d) *Applicability determined by nature and purpose of records.* The applicability of the provisions of this part is determined by the nature and purpose of the records in question, and not by the status or primary functional capacity of the recordkeeper.

§ 2.12-1 Applicability.—Basis and purpose.

(a) The broad coverage provided by § 2.12(a) is appropriate in the light of the remedial purposes of the statutes as well as the practical desirability of certainty and uniformity. Sections 2.12(a)(1) and 2.12(a)(2) simply follow the terms of subsection (a) of the statutes, with some explanatory material for the sake of clarity and explicitness.

(b) Sections 2.12(a)(3) and 2.12(a)(4) are based upon the use by Congress of the phrase "directly or indirectly as-

sisted by any department or agency of the United States". In the light of the multiplicity and extent of Federal programs and policies which can be of assistance to drug and alcoholism programs, this wording strongly suggests an intention to provide the broadest coverage consistent with the literal terms of the statutes. Many programs commence with direct Federal assistance, financial, technical, or both, and later continue with State aid and private, tax-deductible contributions. It would be manifestly contrary to the general policy sought to be effectuated by the legislation if the confidential status of a program's records were to terminate, or even be called into question, by the cessation of direct Federal assistance.

(c) With regard to § 2.12(a)(3), it seems clear that whenever a State or local government is assisted by the Federal government by way of revenue sharing or other unrestricted grants, all of the programs and activities of the State or local government are thereby indirectly assisted, and thus meet that aspect of the statutory criteria for coverage.

(d) Section 2.12(a)(4) follows the doctrine established in *McGlotten v. Connally*, 338 F. Supp. 448 (D.C. D.C., 1972), in which it was held that the deductible status of contributions to an organization constitutes "Federal financial assistance" within the meaning of section 601 of the 1964 Civil Rights Act (42 U.S.C. 2000d). The inclusion of the adjective "indirect" as a modifier of the term "assistance" as used in the provisions of law authorizing this part suggests an intention to provide coverage at least as broad, if not broader than, section 601 of the Civil Rights Act in respect of financial assistance. See, also, *Green v. Connally*, 330 F. Supp. 1150 (D.C. D.C., 1971) aff'd sub. nom. *Coit v. Green*, 404 U.S. 997, 92 S. Ct. 564, 30 L. Ed. 2d 550 (1971).

(e) Section 2.12(b) essentially repeats the interpretation given in § 1401.02(b) of the previous regulation except that it takes account of the special provisions inserted in the new law with reference to the Veterans Administration, and makes clear that the exemption for communications within the military-VA system does not generally apply to records pertaining to civilians.

(f) Section 2.12(c), which deals with the question of how the period covered by any given set of records affects the applicability of these regulations, to them, restates the principle set forth in § 1401.02(a) of the previous regulations, and applies it to records in the field of alcohol abuse as well as drug abuse. The authorizing legislation contains no effective date provisions. A construction which would apply the statutes to records of completely closed treatment episodes, records necessarily made and maintained prior to the enactment of the legislation, would create serious administrative problems. It seems doubtful, in any case, whether such records have been "maintained," within the meaning of the statutes, during any period of time after their enactment. On the other hand, if

treatment is actually carried on after the enactment of the applicable statute, then all the records should be covered irrespective of when treatment was begun, because such records clearly are being "maintained" after the enactment of the legislation.

(g) Section 2.12(d) has been included to make explicit one of the legal implications of the authorizing legislation, which is cast in terms descriptive of the records which are to be confidential rather than of the recordkeepers on whom a duty is thus imposed. The result is that, for example, where a State agency maintains an individual client record which contains identifying information about a client (i.e., patient) receiving treatment or rehabilitation services for drug abuse, such a record is clearly a record maintained in connection with a drug abuse prevention function, and is subject to the provisions of this part. The fact that the record may also be required by statute or regulations pertaining to eligibility for Federal Financial Participation would in no way exempt the record from the prohibitions and requirements of this part. Thus, it would be unlawful and a violation of these regulations for such a record to be made available to a law enforcement agency, or to determine (without the prior written consent of the client) eligibility for other welfare benefits, or for any other administrative or investigative uses or purposes which would involve or result in an identification of the client to a third party.

§ 2.13 General rules regarding confidentiality.—Rules.

(a) *In general.* Records to which this part applies shall be confidential and may be disclosed only as authorized by this part, and may not otherwise be divulged in any civil, criminal, administrative, or legislative proceeding conducted by any Federal, State, or local authority, whether such proceeding is commenced before or after the effective date of this part.

(b) *Unconditional compliance required.* The prohibition upon unauthorized disclosure applies irrespective of whether the person seeking disclosure already has the information sought, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other justification or basis for disclosure not expressly authorized under this part.

(c) *Information covered by prohibition.* The prohibition on unauthorized disclosure covers all information about patients, including their attendance or absence, physical whereabouts, or status as patients, whether or not recorded, in the possession of program personnel, except as provided in paragraph (d) of this section.

(d) *Crimes on program premises or against program personnel.* Where a patient commits or threatens to commit a crime on the premises of the program or against personnel of the program, nothing in this part shall be construed as prohibiting personnel of the program from seeking the assistance of, or re-

porting such crime to, a law enforcement agency, but such report shall not identify the suspect as a patient. In any such situation, immediate consideration should be given to seeking an order under Subpart E of this part to permit the disclosure of such limited information about the patient as may be necessary under the circumstances.

(e) *Implicit and negative disclosures prohibited.* The disclosure that a person (whether actual or fictitious) answering to a particular description, name, or other identification is not or has not been attending a program, whether over a period of time or on a particular occasion, is fully as much subject to the prohibitions and conditions of this part as a disclosure that such a person is or has been attending such a program. Any improper or unauthorized request for any disclosure of records or information subject to this part must be met by a non-committal response.

(f) *In-patients and residents.* The presence of any in-patient in a medical facility or resident in a residential facility for the treatment of drug or alcohol abuse may be acknowledged to callers and visitors with his written consent. Without such consent, the presence of any in-patient or resident in a facility for the treatment of a variety of conditions may be acknowledged if done in such a way as not to indicate that the patient is being treated for drug or alcohol abuse.

§ 2.13-1 General rules regarding confidentiality.—Basis and purpose.

(a) Section 2.13(a) enunciates the general principle of the statutory provisions, and is unchanged from § 1401.03 of the previous regulations.

(b) Sections 2.13(b) and 2.13(c) have been added on the basis of written comments on the draft regulations published August 22, 1974, in which there was a documented report that counsel for a program had advised the program that it could furnish information to the FBI about patients without their written consent and without completing a full judicial proceeding in accordance with Subpart E of this part. Sections 2.13(b) and 2.13(c) should clarify the original intent of the statutes and regulations to the extent of precluding such errors in the future.

(c) In the situation described in § 2.13(d), the desirability of the general prophylactic rule prohibiting disclosures by program personnel about patients regardless of whether such disclosures are from a written record must yield to the practical necessity to permit protection from, and prompt reporting of, criminal acts. In the preface to the first set of regulations issued under 21 U.S.C. 1175, it was emphasized that the operation of that section "in no way creates a sanctuary for criminals." (37 FR 24635, November 17, 1972). Section 2.13(d) is consistent with that contemporaneous administrative construction.

(d) Section 2.13(e) is adapted from § 1401.11 of the August 22, 1974 draft. The suggestion that this part be cited when declining to give information has

been deleted on the basis of comments that correctly pointed out that such a citation, if given by an institution or program maintaining some records covered by this part and some not, would serve to identify the records inquired about as pertaining to treatment covered by this part.

Section 2.13(f) merely clarifies the effect of the preceding paragraphs in the special situations to which paragraph (f) relates.

§ 2.14 Penalty for violations.—Rules.

(a) *Penalty provided by law.* Any person who violates any provision of the authorizing legislation or any provision of this part shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(b) *Application to subsequent offenses.* Where a defendant has committed one offense under either section authorizing this part or any provision of this part authorized by that section, any offense thereafter committed under the same section or any provision of this part authorized under that section shall be treated as a subsequent offense.

§ 2.14-1 Penalty for violations.—Basis and purpose.

(a) Section 2.14 states the criminal penalty provided for in subsection (f) of the sections authorizing this part. It is included in this part for convenience and completeness. Some of the comments received on this section when originally proposed suggested that criminal penalties for violation should include imprisonment, but such a change would have to be made by legislation rather than rulemaking.

(b) Section 2.14(b) clarifies the intention that the "subsequent offense" need not be identical to the first offense, as long as it is committed with respect to the same statutory section. For example, a person whose first offense had consisted of improperly releasing the name of a patient in an alcoholism treatment program would be punishable for a "subsequent offense" if he later gives out information from the diagnostic work-up of an alcoholism patient.

§ 2.15 Minor patients.—Rules.

(a) *Definition of minor.* The term "minor" means a person who has not attained the age of 18 years or, in a State where a different age is expressly provided by State law as the age at which a person ceases to be a minor, the age prescribed by the law of such State.

(b) *Consent to disclosure in general.* Except as provided in paragraph (c), where consent is required for any disclosure under this part, such consent in the case of a minor must be given by both the minor and his parent, guardian, or other person authorized under State law to act in his behalf, but any disclosure made after the patient has ceased to be a minor may be consented to only by the patient.

(c) *Rule when State law authorizes treatment without parental consent.* Whenever a patient, acting alone, has the

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legal capacity under the applicable State law to apply for and obtain such diagnosis, counselling, administration of medication, or other services as actually are or were provided to him by the program with respect to which he is or was a patient, any consent required for disclosure under this part may be given only by the patient, notwithstanding the fact that the patient may be a minor.

(d) *Initial contacts.* When a minor applies for services under circumstances other than those described in paragraph (c) of this section, the fact of such application may not be disclosed, except as an incident to a communication authorized under paragraph (f) of this section, without consent of the applicant, to the applicant's parent, guardian, or other person authorized under State law to act on behalf of the applicant. When such an applicant refuses consent, it must be explained to the applicant that while he or she has the right (subject to the provisions of paragraph (f) of this section) to withhold such consent, the services applied for cannot be provided without it.

(e) *Collection or attempted collection of payment for services.* Where State law authorizes the furnishing of services to a minor without the consent of the minor's parent or guardian, no inquiry may be made of the parent's or guardian's financial responsibility, and no bill, statement, request for payment, or any other communication in respect of such services may be transmitted directly or indirectly to such parent or guardian, without the express written consent of the patient. Such consent may not be made a condition of the furnishing of services except in the case of a program which is not required by law, and does not in fact hold itself out as willing, to furnish services irrespective of ability to pay.

(f) *Applicant lacking capacity for rational choice.* When, in the judgment of a program director a minor applicant for services, because of extreme youth or mental or physical condition, lacks the capacity to make a rational decision on whether to consent to the notification of a parent or guardian, and the situation of the applicant poses a substantial threat to the life or physical well being of the applicant or any other individual, and such threat might be reduced by communicating the relevant facts to a parent or guardian of the applicant, such facts may be so communicated by the program director or by program personnel authorized by the director to do so.

§ 2.15-1 Minor patients.—Basis and purpose.

(a) The statutes authorizing this part are totally silent on the issue of the capacity of a minor to give consent for disclosures, and there is nothing in the legislative history to suggest that the question was ever considered by Congress. The question is, however, one which arises repeatedly, and it is therefore appropriately addressed under the general rulemaking authority conferred

by subsection (g) of the authorizing legislation.

(b) Perhaps no legal issues are more highly charged than those affecting the relationship of parent and child. Since Congress has not evidenced an intention to affect this relationship, it is clear that local law should govern, and the task of rulemaking is limited to that of insuring, as far as possible, that the results under Federal law are consistent with local policy.

(c) Where a State has authorized the furnishing of treatment or other services of a given type to a minor without notice to or consent by the parent or guardian, it seems clear that a consistent Federal policy with respect to disclosure requires that consent for any disclosure of the treatment record be given by the minor. This policy, moreover, should not be frustrated by attempts to enforce parental financial responsibility in a situation where the State itself has determined that the minor should have a right to obtain services without involving the parent.

(d) A much more difficult problem is presented in the case of a minor who applies for services in a jurisdiction which has not determined that a minor should have the right to obtain them without parental knowledge or consent. The question may arise as to whether the clinician has an ethical or legal duty to notify the parent which conflicts with a duty of nondisclosure. The rules in § 2.15 are based upon the theory that Federal law should not invalidate a State policy which prohibits treatment without parental consent, but that keeping confidential a mere application for treatment is not ordinarily a sufficient transgression of such a State policy as to require an exception to the general Federal policy prohibiting disclosure of an application for services without the consent of the applicant.

(e) Section 2.15(f) deals with the case of the minor applicant who lacks the capacity to make a rational choice about consenting to disclosure. It is based upon the theory that where a person is actually as well as legally incapable of acting in his own interest, disclosures to a person who is legally responsible for him may be made to the extent that the best interests of the patient clearly require. Any other rule could subject clinicians to an intolerable choice between violating the provisions of this part on the one hand, or failing to take action to avoid a preventable tragedy involving a minor, on the other. The statutes authorizing this part should not be read as requiring such a choice.

§ 2.16 Incompetent and deceased patients.—Rules.

(a) *Incompetent patients other than minors.* Where consent is required for any disclosure under this part, such consent in the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(b) Deceased patients.

(1) *In general.* Except as provided in paragraph (b) (2) of this section, where consent is required for any disclosure of this part, such consent in the case of records of a deceased patient may be given by an executor, administrator, or other personal representative. If there is no appointment of a personal representative, such consent may be given by the patient's spouse, or if none, by any responsible member of the patient's family.

(2) *Vital statistics.* In the case of a deceased patient, disclosures required under Federal or State laws involving the collection of death and other vital statistics may be made without consent.

§ 2.16-1 Incompetent and deceased patients.—Basis and purpose.

Section 2.16 essentially repeats the substance of § 1401.04 of the previous regulations, broadened to reflect the fact that the statutes now allow any consensual disclosures permitted by the regulations, and to cover the situation of deceased patients for whom no formal appointment of an executor, administrator, or other personal representative has been made. Written comments were received to the effect that the power to consent to disclosure in the case of a deceased patient should be limited to a personal representative. The expense of probate or administration in some jurisdictions could cause financial hardship to survivors, and on balance it is believed that where the assets of an estate are insufficient to justify the appointment of a personal representative, the public interest is served by permitting others to consent to disclosure.

§ 2.17 Security precautions.—Rules.

(a) *Precautions required.* Appropriate precautions must be taken for the security of records to which this part applies. Records containing any information pertaining to patients shall be kept in a secure room, or in a locked file cabinet, safe, or other similar container, when not in use.

(b) *Policies and procedures.* Depending upon the type and size of the program, appropriate policies and procedures should be instituted for the further security of records. For example, except where this function is personally performed by the program director, a single member of the program staff should be designated to process inquiries and requests for patient information, and a written procedure should be in effect regulating and controlling access by those members of the staff whose responsibilities require such access, and providing for accountability.

§ 2.17-1 Security precautions.—Basis and purpose.

The enormous variations in both the size and the type of programs to which this part is applicable preclude the formulation of specific requirements with respect to the physical security of records. Almost any requirement which could be laid down would, under some circumstances, either be impracticable or

perverse in its effects. For example, in a facility handling a variety of medical records, all of which are confidential and so marked, a requirement that those pertaining to drug or alcohol treatment be marked in any distinctive way would merely serve to identify such records as pertaining to drug or alcohol treatment—precisely the opposite of the intended result. The purpose of § 2.17, which is based upon § 1401.25 of the previous regulations, is to alert programs to the necessity of exercising due care with respect to the security of patient records.

§ 2.18 Extent of disclosure.—Rule.

Any disclosure made under this part, whether with or without the patient's consent, shall be limited to information necessary in the light of the need or purpose for the disclosure.

§ 2.18-1 Extent of disclosure.—Basis and purpose.

(a) Section 2.18 expresses the general principle, which has application in many different contexts, that any disclosure from records covered by this part should be limited to information necessary in the light of the need or purpose for the disclosure. It is identical to § 1401.06 of the previous regulations.

(b) This section should not be misunderstood as imposing a limitation on the scope of records which may or should be made available to health agencies conducting inspections as described in § 2.55. All of the records maintained by a program may be relevant to such inspection. The Congress has determined that disclosure under such circumstances is not a violation of the statutes authorizing this part; where such disclosure is required by Federal or State law, and the inspecting agency is a qualified State health agency as defined in § 2.55(e)(1), it becomes the responsibility of that agency to protect the confidentiality of information it acquires in the course of its lawful activities.

§ 2.19 Undercover agents and informants.—Rules.

(a) *Definitions.* As used in this section, § 2.19-1, and §§ 2.67 and 2.67-1,—

(1) The term "undercover agent" means a member of any Federal, State, or local law enforcement or investigative agency whose identity as such is concealed from either the patients or personnel of a program in which he enrolls or attempts to enroll.

(2) The term "informant" means a person who, at the request of a Federal, State, or local law enforcement or investigative agency or officer, carries on observation of one or more persons enrolled in or employed by a program in which he is enrolled or employed, for the purpose of reporting to such agency or officer information concerning such persons which he obtains as a result of such observation subsequent to such request.

(b) *General prohibition.* Except as otherwise provided in paragraph (c) of this section, or as specifically author-

ized by a court order granted under § 2.67,—

(1) No undercover agent or informant may be employed by or enrolled in any alcohol or drug abuse treatment program;

(2) No supervisor or other person having authority over an undercover agent may knowingly permit such agent to be or remain employed by or enrolled in any such program; and

(3) No law enforcement or investigative officer may recruit or retain an informant with respect to such a program.

(c) *Exceptions.* The enrollment of a law enforcement officer in a treatment program shall not be deemed a violation of this section if (1) such enrollment is solely for the purpose of enabling the officer to obtain treatment for his own abuse of alcohol or drugs, and (2) his status as a law enforcement officer is known to the program director.

§ 2.19-1 Undercover agents and informants.—Basis and purpose.

(a) In many instances, persons who are patients in treatment programs are making their first tentative efforts toward re-integration into productive society. They may be both vulnerable and suspicious, and the presence in a treatment program of undercover law enforcement agents or informants can have a devastating effect on the program's morale and therapeutic effectiveness. Moreover, it would appear that the purpose of such agents or informants may be to obtain precisely the type of personal information which might be revealed by inspection of counselor notes and other patient records maintained by the program. Thus, the placing of an undercover agent or informant in a program, either as a patient or as an employee, would appear to be contrary to the purposes for which the provisions of law authorizing this part were enacted, and properly subject to prohibition under regulations expressly authorized to carry out those purposes.

(b) From a policy standpoint, § 2.19 is based on the reasoning that while the use of undercover agents and informants in treatment programs is ordinarily to be avoided, there may occasionally arise circumstances where their use may be justified. Accordingly, where a showing is made in an application for an order under § 2.67 that the criteria set forth in that section are satisfied, the court may grant such an order.

(c) When this section of the regulations was proposed, numerous written comments were received urging that there be an absolute prohibition on the use of undercover agents and informants, and most of the witnesses at the hearings who addressed the issue at all testified to the same effect. A number of comments were received to the effect that § 2.19 should be dropped altogether, but this request was always clearly and often explicitly predicated on the assumption that failure to say anything about undercover agents and informants would make their use illegal. Our view is to the contrary: we think that the

statutes, standing alone, do not prohibit the practice, and thus that in the absence of a specific prohibition in these regulations, the use of undercover agents and informants in treatment programs would not be unlawful. Since this is a view which we believe to be shared by the law enforcement and investigative agencies which are affected by § 2.19, there is as a practical matter no alternative to predicated these regulations upon its correctness.

(d) However desirable it may be to limit the use of undercover agents and informants in treatment programs, we think a strong argument can be made against our power to impose an absolute prohibition. To the extent that the practice is susceptible to regulation through the rulemaking process at all, it is on the theory that it opens the way to disclosure of information which may or should be in program records, and thus is contrary to the purposes of the statutes. Since subsection (g) of the statutes confers express rulemaking authority to carry out these purposes, regulation of the use of undercover agents and informants is a proper subject for the exercise of that authority. But even the express statutory prohibition against direct disclosure of the content of patient records is subject to the power of the courts to authorize such disclosure under subsection (b)(2)(C) of the statutes. It seems difficult to argue that Congress intended to confer on rulemaking agencies the authority to impose an absolute prohibition (even though its own restrictions (other than those on disclosures of patient identities from secondary records) are subject to being set aside by court order in particular cases. Since we have not attempted to exercise such an authority, it is not necessary to decide at this time whether it was conferred.

(e) A careful reading of the definitions set forth in § 2.19(a) is crucial to an understanding of the prohibitions which are imposed by § 2.19. Objections to the section were made informally but vigorously on behalf of the Drug Enforcement Administration, on the ground that the testimony of informants or undercover agents is frequently if not normally essential to the successful prosecution of cases arising under the Controlled Substances Act. It was said that in the form originally proposed, the section would cut off from treatment those who might agree to cooperate with law enforcement authorities, a result both inhumane and counterproductive. As the definition of an informant is intended to make clear, however, it is his function vis-a-vis personnel and fellow patients in the program in which he is enrolled which is controlling, and not his relationship, *per se*, with an investigative agency.

(f) Finally, the definition of informant is intended to clarify the distinction between an informant and an ordinary witness. It is the element of prearrangement which is crucial. In one of the comments received on § 2.19 as proposed, it was urged that treatment programs should be considered as sanctuaries, but such a result was explicitly disclaimed in the

initial publication of the previous regulations (37 FR 24636). In so saying, we are by no means insensitive to the anxieties repeatedly expressed in both testimony and comments on this section, but we believe that the prohibition contained in § 2.19 and the procedures and criteria set forth in § 2.67 provide a measure of relief which is consistent with the structure and intent of the underlying statutes.

§ 2.20 Identification cards.—Rules.

(a) *Required use prohibited.* No program may require or request any patient to carry in his or her possession, while away from the program premises, an identification card or other form of identification which is issued by the program or which would tend to identify the bearer as a participant in it or any similar program.

(b) *Conditions of voluntary use.* Nothing in this section prohibits a program from issuing an identification card to a patient if the patient's counselor or other authorized member of the program staff has explained to the patient that acceptance and use of the card is entirely voluntary and that neither an initial rejection nor a subsequent discontinuation of its use will in any way prejudice his or her record or standing in the program. In the case of any patient to whom an identification card or similar device was issued prior to the effective date of this section, or subsequent thereto in violation of this section, a counselor or other authorized member of the program staff shall explain to the patient his right to turn it in without prejudice at any time.

(c) *On-premises exemption.* Nothing in this section prohibits a program from maintaining and using on its premises cards, photographs, tickets, or other devices, or using passwords or other information, to assure positive identification of patients, correct recording of attendance or medication, or for other proper purposes, as long as no pressure is brought on any patient to carry any such device when away from the program premises.

§ 2.20-1 Identification cards.—Basis and purpose.

Section 2.20 is in furtherance of one of the basic purposes of the statutes authorizing this part, namely, protection of patients from improper disclosure of their status as such. Regrettably, there appear to be areas where possession of a treatment program identification card can be prejudicial to a person under arrest or subjected to a search. In any part of the country, the accidental display or circulation of such a card by reason of its loss or theft could have adverse consequences for a variety of reasons. Since programs have other means of achieving the ends which identification cards are meant to serve, patients who do not wish to assume whatever risks may be involved in carrying such cards should not be compelled to do so.

§ 2.21 Disposition of discontinued program records.—Rules.

(a) *General rule.* When a program discontinues operations or is taken over or acquired by another program, its records to which this part applies with respect to any patient may, with the written consent of that patient, be turned over to the acquiring program or, if none, to any other program specified in the patient's consent. Except as otherwise provided in this section, any records to which this part applies, but for the transfer of which patient consent is not obtained, shall be either completely purged of patient identifying information, or destroyed. If any effort to obtain consent for transfer is made, it shall be by means which minimize the likelihood of accidental or incidental disclosure to any third party of the patient's identity as such.

(b) *Retention period.* Where records are required by law to be kept for a specified period, and such period does not expire until after the discontinuation or acquisition of the program, and patient consent for their transfer is not obtained, such records shall be sealed in envelopes or other containers marked or labelled as follows: "Records of (insert name of program) required to be maintained pursuant to (insert citation to law or regulation requiring that records be kept) until a date not later than December 31, (insert appropriate year)." The same procedure may be followed when it is determined to retain records for the period of any applicable statute of limitations.

(c) *Custodial retention.* Records marked and sealed in accordance with paragraph (b) of this section may be held by any lawful custodian, but may be disclosed by such custodian only under such circumstances and to such extent as would be permissible for the program in which they originated. As soon as practicable after the date specified on the label or legend required to be affixed pursuant to paragraph (b) of this section, the custodian shall destroy the records. In the case of any program terminated by reason of bankruptcy, the expense of compliance with this paragraph shall be an expense of administration of the bankrupt estate.

§ 2.21-1 Disposition of discontinued program records.—Basis and purpose.

While arguments can be made for requiring the destruction of records at the conclusion of their useful clinical life, there is wide disagreement on its span, and there are in addition research considerations which argue for an even longer period of retention. Except in the case of discontinued programs, it therefore seems best to leave this issue for determination by the programs concerned.

§ 2.22 Former employees and others.—Rules.

The prohibitions of this part on disclosure of patient records or information contained therein apply to all individuals

who are personnel of treatment programs, researchers, auditors, evaluators, service organizations, or others having access to such records or information, and continue to apply to such individuals with respect to such records or information after the termination of their employment or other relationship or activity giving rise to such access.

§ 2.22-1 Former employees and others.—Basis and purpose.

The prohibition contained in § 2.22 is arguably an interpretation of the authorizing legislation which would be necessary as a matter of law even in the absence of this part; its validity as an exercise of the rulemaking power conferred by subsection (g) of the authorizing legislation seems beyond dispute.

§ 2.23 Relationship to State laws.—Rules.

The enactment of the provisions of law authorizing this part was not intended to preempt the field of law covered thereby to the exclusion of State laws not in conflict therewith. If a disclosure permitted under the provisions of this part, or under a court order issued pursuant thereto, is prohibited under State law, nothing in this part or in the provisions of law authorizing this part may be construed to authorize any violation of such State law. No State law, however, may either authorize or compel any disclosure prohibited by this part.

§ 2.23-1 Relationship to State laws.—Basis and purpose.

Section 2.23 sets forth publicly an interpretation which, in informal communications, has consistently been given to 21 U.S.C. 1175 since its original enactment, and clearly has equal applicability to 42 U.S.C. 4582.

§ 2.24 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act.—Rules.

(a) *Research privilege description.* In some instances, there may be concurrent coverage of a program or activity by the provisions of this part and by a regulation or other administrative action under section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c)). The latter two provisions of law, referred to hereinafter in this section as the research privilege sections, confer on the Secretary of Health, Education, and Welfare, and on the Attorney General, respectively, the power to authorize researchers to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subject of such research. The Secretary of Health, Education, and Welfare may grant this privilege with respect to any "research on mental health, including research on the use and effect of alcohol and other psychoactive drugs." The Attorney General's power is conferred as part of a section authorizing

research related to enforcement of laws under his jurisdiction concerning substances which are or may be subject to control under the Controlled Substances Act, but is not expressly limited to such research. Regardless of whether a grant of research privilege is made by the Secretary or by the Attorney General, it is expressly provided that persons who obtain it "may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding to identify" the subjects of research for which the privilege was obtained.

(b) *Comparison with authority for this part.* Although they deal, in a sense, with the same subject matter, and may on occasion concurrently cover the same transactions, it is important to note the differences between the research privilege sections (21 U.S.C. 872(c) and 42 U.S.C. 242a(a)) and the provisions of law (21 U.S.C. 1175 and 42 U.S.C. 4582) which authorize this part. Briefly, these differences are as follows:

(1) Although they contain broad grants of express rulemaking authority, the provisions of law by which this part is authorized are self-executing in the sense that they are operative irrespective of whether the rulemaking authority is exercised. The protection afforded by the research privilege sections, on the other hand, can only come into existence as a result of affirmative administrative action.

(2) The provisions of law authorizing this part, as well as the provisions of this part itself, impose affirmative duties with respect to the records to which they apply, and the violation of such duties is subject to criminal penalties. To the extent that a privilege is thereby created, it grows out of the duties thus imposed. The research privilege sections, by contrast, impose no duties by their own terms, and if any duties are implied from their existence, they would have to be enforced on the basis of an implicit civil liability for damages or by equitable relief, as there are no criminal or administrative sanctions available.

(3) The exercise of the authority conferred by the research privilege sections is subject to administrative discretion, whereas in the case of the duties imposed under this part there is judicial discretion, within the limits and subject to procedures and criteria prescribed by statute and regulation, to grant relief in particular cases.

(c) *Grant of research privilege not affected by (b) (2) (C) order.* The issuance of an order under subsection (b) (2) (C) of either of the sections authorizing this part (21 U.S.C. 1175 and 42 U.S.C. 4582) in no way affects the continuing effectiveness of any exercise of the authority of the Secretary of Health, Education, and Welfare under 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) or the Attorney General under section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c)).

§ 2.21-1 Relationship to section 303(a) of Public Health Service Act and section 502(c) of Controlled Substances Act.—Basis and purpose.

(a) In Pub. L. 93-282, the Congress expressly amended (by sections 122(a) and 303(a), 88 Stat. 131 and 137) the provisions of law which authorize this part, expressly amended (by section 122 (b), 88 Stat. 132) the research privilege section under the Secretary's jurisdiction, and made explicit reference (in section 303(d), 88 Stat. 139) to the regulations previously issued by the Special Action Office for Drug Abuse Prevention reconciling the provisions of section 408 of the Drug Abuse Office and Treatment Act of 1972 with the provisions of the research privilege sections. When the bill which became Pub. L. 93-282 was before the House of Representatives for its last Congressional consideration before transmission to the President, its floor manager, Chairman Staggers of the Committee on Interstate and Foreign Commerce, inserted in the Record a detailed analysis of the bill in its final form (Congressional Record, daily edition, May 6, 1974, page H3563). This analysis contained the following paragraph:

The relationship of section 303(a) of the Public Health Service Act, authorizing the administrative grant of absolute confidentiality for research, to section 408 of the Drug Abuse Office and Treatment Act of 1972, requiring that Federally-connected drug abuse patient records generally be kept confidential, has been correctly described in an interpretative regulation, 21 C.F.R. 1401.61 and 1401.62, which was upheld in *People v. Newman*, 32 N.Y. 2d 379, [reversing] 336 N.Y.S. 2d 127, 298 N.E. 2d 651 (1973); *certiorari denied*, [414] U.S. [1163], 94 S. Ct. 927, [39] L. Ed. 2d 116 (1974). For that reason, among others, section 303(d) of the Senate amendment expressly continues the effectiveness of the current regulation promulgated by the Director of the Special Action Office for Drug Abuse Prevention. Thus, although section 502(c) of the Comprehensive Drug Abuse Prevention and Control Act of 1970 is not explicitly referred to in this legislation, the congressional intent is clear that the authority conferred by that section was not modified by Pub. L. 92-255, and is not intended to be modified by the bill now before the House.

(b) Sections 2.24 and 2.61 restate, in substance, the interpretative rules (§§ 1401.61 and 1401.62 of the previous regulations) referred to in the passage quoted in paragraph (a) of this section, modified to reflect the amendment made to section 303(a) of the Public Health Service Act (42 U.S.C. 242(a)) by Pub. L. 93-282.

Subpart C—Disclosures With Patient's Consent

§ 2.31 Written consent required.—Rules.

(a) *Form of consent.* Except as otherwise provided, a consent for a disclosure under this part must be in writing and must contain the following:

(1) The name of the program which is to make the disclosure.

(2) The name or title of the person or organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose or need for the disclosure.

(5) The extent or nature of information to be disclosed.

(6) A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon, and a specification of the date, event, or condition upon which it will expire without express revocation.

(7) The date on which the consent is signed.

(8) The signature of the patient and, when required under § 2.15, the signature of a person authorized to give consent under that section; or, when required under § 2.16, the signature of a person authorized to sign under that section in lieu of the patient.

(b) *Duration of consent.* Any consent given under this subpart shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

(c) *Disclosure prohibited with deficient consent.* No program may disclose any information on the basis of a consent form—

(1) which on its face substantially fails to conform to any of the requirements set forth in paragraph (a), of this section, or

(2) which is known, or in the exercise of reasonable care should be known, to the responsible personnel of the program to be materially false in respect to any item required to be contained therein pursuant to paragraph (a) of this section.

(d) *Falsification prohibited.* No person may knowingly make, sign, or furnish to a program any consent form which is materially false with respect to any item required to be contained therein pursuant to paragraph (a) of this section.

§ 2.31-1 Written consent required.—Basis and purpose.

(a) The use of a consent form containing all of the elements specified in § 2.31(a) is necessary to assure compliance with the requirements of this subpart. Under § 1401.21 of the previous regulations, a much more abbreviated form was permissible, because the circumstances under which any consent could be given were very strictly limited. Now that the authorizing legislation permits disclosure with consent "to such extent, under such circumstances, and for such purposes as may be allowed under regulations," the consent form should show on its face information sufficient to indicate compliance with the regulations.

(b) Sections 2.31(b), 2.31(c), and 2.31(d) are an exercise of the general rulemaking authority in subsection (g) of the authorizing legislation. Section 2.31(c) imposes a legal liability on programs and their personnel for disclosure of information on the basis of a materially

deficient consent, and § 2.31(d) imposes liability on any person who submits a falsified consent form to a program.

§ 2.32 Prohibition on redisclosure.—Rules.

(a) *Notice to accompany disclosure.* Whenever a written disclosure is made under authority of this subpart, except a disclosure to a program or other person whose records pertaining to the patient are otherwise subject to this part, the disclosure shall be accompanied by a written statement substantially as follows: "This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose." An oral disclosure may be accompanied or followed by such a notice.

(b) *Consent required for redisclosure.* A person who receives information from patient records and has been notified substantially in accordance with paragraph (a) of this section is prohibited from making any disclosure of such information except with the specific written consent of the person to whom it pertains, or as otherwise permitted under this part.

(c) *Restriction on redisclosure.* Whenever information from patient records is needed by any person, such information must be obtained directly from the program maintaining such records and not from another person to whom disclosure thereof has been made, except where the initial disclosure was intentionally and expressly made for the purpose of redisclosure (as for example in the case of an employment agency), or the information is no longer available from the program and redisclosure is not prohibited by any other provision of this part.

§ 2.32-1 Prohibition on redisclosure.—Basis and purpose.

(a) Section 2.32 is intended to provide a reasonable protection against redisclosure of information disclosed with consent in accordance with this subpart. There is, of course, no problem where the information becomes part of a record which is itself subject to this part because it is maintained in connection with the performance of a covered substance abuse prevention function. The difficulty arises when the disclosure is made to those whose records are not otherwise affected by this part. To attempt to make all of the provisions of this part applicable to such recipients with respect to such information might raise serious problems of legality, administrative feasibility, and fairness, but where they are given actual notice that specific patient consent is normally required for redisclosure, we think they can and should be bound by it.

(b) Oral disclosures are not mandatorily covered because they should rarely be made to any recipient with whom the program does not have a continuing relationship. Where such a relationship exists or the program is otherwise satisfied that the recipient understands and will respect the confidential nature of the information supplied, there seems no need to add to the already heavy load of paperwork with which programs must contend.

§ 2.33 Diagnosis, treatment, and rehabilitation.—Rules.

(a) *Disclosure authorized.* Where consent is given in accordance with § 2.31, disclosure of information subject to this part may be made to medical personnel or to treatment or rehabilitation programs where such disclosure is needed in order to better enable them to furnish services to the patient to whom the information pertains.

(b) *Traveling, incarcerated, or hospitalized patients on medication.* Where a patient on medication is at a distance from his normal residence or treatment program or is incarcerated or hospitalized, or is otherwise unable to deliver a written consent to his treatment program at the time the disclosure is needed, confirmation of the patient's status and information necessary to appropriately continue or modify his medication may be given to medical personnel in a position to provide services to the patient upon the oral representation of such personnel that the patient has requested medication and consented to such disclosure. Any program making a disclosure in accordance with this paragraph shall make a written memorandum showing the name of the patient, or the patient's case number assigned by the program, the date and time the disclosure was made, the information disclosed, and the names of the individuals by whom and to whom it was made.

§ 2.33-1 Diagnosis, treatment, and rehabilitation.—Basis and purpose.

(a) Section 2.33(a) is a restatement of the policy set forth in § 1401.22(a) of the previous regulations, expanded to make explicit reference to nonmedical counseling and other treatment and rehabilitative services.

(b) Section 2.33(b) clarifies the corresponding provision in § 1401.22(a) of the previous regulations by specifying how and through whom oral consent can be given, and limiting the disclosure to that necessary to determine appropriate medication.

§ 2.34 Prevention of certain multiple enrollments.—Rules.

(a) *Definitions.* For the purposes of this section and § 2.55—

(1) The terms "administer", "controlled substance", "dispense", "maintenance treatment", and "detoxification treatment" shall respectively have the meanings defined in paragraphs (2), (6), (10), (27), and (28) of section 102 of the

Controlled Substances Act (21 U.S.C. 802).

(2) The term "program" means a program which offers maintenance treatment or detoxification treatment.

(3) The term "permissible central registry" means a qualified service organization which collects or accepts, from two or more programs (referred to hereinafter as member programs) all of which are located either within a given State or not more than 125 miles from the nearest point on the border of such State, patient identifying information about persons applying for maintenance treatment or detoxification treatment for the purpose of enabling the member programs to prevent any individual from being concurrently enrolled in more than one such program.

(b) *Use of central registries prohibited except as expressly authorized.* The furnishing of patient identifying information by a program to any central registry which fails to meet the definition of a permissible central registry set forth in paragraph (a)(3) of this section is prohibited, and the furnishing of patient identifying information to or by any central registry except as authorized in this section is prohibited. Information pertaining to patients held by a central registry may be furnished or used in accordance with paragraphs (e), (f), and (g) for the purpose of preventing multiple enrollments, but may not be otherwise furnished or used in connection with any legal, administrative, supervisory, or other action with respect to any patient.

(c) *Safeguards and procedures required.* To minimize the likelihood of disclosures of information to impostors or others seeking to bring about unauthorized or improper disclosure, any communications carried on by programs pursuant to this section must be conducted (1) by authorized personnel designated in accordance with § 2.17(b), and (2) in conformity with procedures established in accordance with that section.

(d) *Disclosures with respect to patients in treatment.* A member program may supply patient identifying information and information concerning the type of drug used or to be used in treatment and the dosage thereof, with relevant data to a permissible central registry with respect to any patient—

(1) When the patient is accepted for treatment,

(2) When the type or dosage of the drug is changed, and

(3) When the treatment is interrupted, resumed, or terminated.

(e) *Disclosures with respect to applications.* When any person applies to a program for maintenance treatment or detoxification treatment, then for the purpose of inquiring whether such person is currently enrolled in another program for such treatment, the program may furnish patient identifying information with respect to such person—

(1) To any permissible central registry of which the program is a member, and

(2) To any other program which is not more than 200 miles distant and which is not a member of any central registry of which the inquiring program is a member.

(f) *Program procedure in case of apparent concurrent enrollment.* When an inquiry pursuant to paragraph (e) (2) is made of another treatment program and its response is affirmative, the two programs may engage in such further communication as may be necessary to establish whether an error has been made, and if none, the programs should proceed in accordance with sound clinical practice and any applicable regulations pertaining to the type of treatment involved.

(g) *Registry procedure in case of apparent concurrent enrollment.* When an inquiry pursuant to paragraph (e) (1) is made of a permissible central registry and its response is affirmative, it may advise the inquiring program of the name, address, and telephone number of the other program, or it may advise the other program of the identity of the patient and the name, address, and telephone number of the inquiring program, or it may do both, and in any case the two programs may then communicate as provided in paragraph (f) above.

(h) *Advice to patients.* When the policies and procedures of any program involve any disclosures pursuant to this section, before any patient is accepted for or continued in treatment (other than detoxification treatment) after September 30, 1975, written consent in accordance with § 2.31 shall be obtained. Such consent shall set forth a current list of the names and addresses either of any programs or of any central registries to which such disclosures will be made. Notwithstanding the requirement of § 2.31 (a) (2), such consent shall be effective with respect to any other such program thereafter established within 200 miles, or any registry serving such programs, and shall so state. Such consent shall be effective for as long as the patient remains enrolled in the program to which it is given.

§ 2.34-1 Prevention of certain multiple enrollments.—Basis and purpose.

Section 2.34 is based upon § 1401.43 of the previous regulations. It was omitted from the August 22, 1974 draft, but comments on the omission made it clear that in certain areas of the country, central registries are a functional component of the treatment system, and that regulations to guide their operations are needed.

§ 2.35 Legal counsel for patient.—Rules.

When a bona fide attorney-client relationship exists between an attorney-at-law and a patient, disclosure of any information in the patient's records may be made to the attorney upon the written application of the patient endorsed by the attorney. Information so disclosed may not be further disclosed by the attorney.

§ 2.35-1 Legal counsel for patient.—Basis and purpose.

Section 2.35 simplifies and broadens the statement of the policy embodied in

§ 1401.25 of the previous regulations. Its purpose is to assure the availability to the attorney, with his client's consent, of any information needed as a basis for advice and counsel. The purpose of the prohibition on further disclosure by the attorney is to guard against the possibility that the attorney might be forced to serve as a conduit for otherwise prohibited disclosures to third parties. Ordinarily, the attorney-client privilege would suffice, but that privilege is subject to waiver by the client, whereas this prohibition is not. Where there is a need for disclosure to a third party of any given information about any patient, this prohibition in no way affects the availability of other sections of this part to authorize such disclosure by the program.

§ 2.36 Patient's family and others.—Rule.

Where consent is given in accordance with § 2.31, information evaluating his current or past status in a treatment program may be furnished to any person with whom the patient has a personal relationship unless, in the judgment of the person responsible for the patient's treatment, the disclosure of such information would be harmful to the patient.

§ 2.36-1 Patient's family and others.—Basis and purpose.

Section 2.36 expresses the same policy as was embodied in § 1401.27 of the previous regulations, broadened to reflect the expanded authority for consensual disclosure under the authorizing legislation.

§ 2.37 Third-party payers and funding sources.—Rules.

(a) *Acquisition of information.* Disclosure of patient information to third-party payers or funding sources may be made only with the written consent of the patient given in accordance with § 2.31 and any such disclosure must be limited to that information which is reasonably necessary for the discharge of the legal or contractual obligations of the third-party payer or funding source.

(b) *Prohibition on disclosure.* Where a funding source or third-party payer maintains records of the identity of recipients of treatment or rehabilitation services for alcohol or drug abuse such records are, under the authorizing legislation, maintained in connection with the performance of an alcohol or drug abuse prevention function and are subject to the restrictions upon disclosure set forth in this part.

§ 2.37-1 Third-party payers and funding sources.—Basis and purpose.

Section 2.37 is based upon the general authority to prescribe regulations to carry out the purposes of the authorizing legislation. The great diversity of contractual arrangements and legal requirements under which the operations of third-party payers and funding sources are carried on precludes the prescription of detailed records management instructions in these regulations, even if that were otherwise desirable. The general principles set forth in § 2.37, however, should clarify the question of coverage,

and where coverage exists, provide a standard which will minimize the likelihood of violations. See also § 2.12-1(g).

§ 2.38 Employers and employment agencies.—Rules.

(a) *Disclosure permitted.* Where consent is given in accordance with § 2.31, a program may make disclosures in accordance with this section.

(b) *Eligible recipients.* A program may make disclosures under this section to public or private employment agencies, employment services, or employers.

(c) *Scope of disclosure.* Ordinarily, disclosures pursuant to this section should be limited to a verification of the patient's status in treatment or a general evaluation of progress in treatment. More specific information may be furnished where there is a bona fide need for such information to evaluate hazards which the employment may pose to the patient or others, or where such information is otherwise directly relevant to the employment situation.

(d) *Criteria for approval.* A disclosure under this section may be made if, in the judgment of the program director or his authorized representative appointed as provided in § 2.17(b), the following criteria are met:

(1) The program has reason to believe, on the basis of past experience or other credible information (which may in appropriate cases consist of a written statement by the employer), that such information will be used for the purpose of assisting in the rehabilitation of the patient and not for the purpose of identifying the individual as a patient in order to deny him employment or advancement because of his history of drug or alcohol abuse.

(2) The information sought appears to be reasonably necessary in view of the type of employment involved.

§ 2.38-1 Employers and employment agencies.—Basis and purpose.

Section 2.38 is based on the rulemaking power conferred by subsection (b) (1) of the authorizing legislation, and is adapted from § 1401.26 of the previous regulations. Its purpose is to allow disclosures reasonably necessary and appropriate to facilitate the employment of patients and former patients, while protecting patients against unnecessary or excessively broad disclosures. It was urged in a comment received on the August 22, 1974 draft that disclosures to employers be flatly prohibited on the ground that the employer's sole legitimate concern is with on-the-job performance. While we are not unsympathetic to this view, a countervailing consideration is that in the case of an employee or applicant who is known by the employer to have a problem with drugs or alcohol, knowledge by the employer of a genuine effort by the employee to deal with it can make the difference between a job and no job.

§ 2.39 Criminal justice system referrals.—Rules.

(a) *Consent authorized.* Where participation by an individual in a treatment program is made a condition of such in-

individual's release from confinement, the disposition or status of any criminal proceedings against him or the execution or suspension of any sentence imposed upon him, such individual may consent to unrestricted communication between any program in which he is enrolled in fulfillment of such condition and (1) the court granting probation, or other post-trial or pretrial conditional release, (2) the parole board or other authority granting parole, or (3) probation or parole officers responsible for his supervision.

(b) *Duration of consent.* Where consent is given for disclosures described in paragraph (a) of this section, such consent shall expire sixty days after it is given or when there is a substantial change in such person's status, whichever is later. For the purposes of this section, a substantial change occurs in the status of a person who, at the time such consent is given, has been—

(1) Arrested, when such person is formally charged or unconditionally released from arrest;

(2) Formally charged, when the charges have been dismissed with prejudice, or the trial of such person has been commenced;

(3) Brought to a trial which has commenced, when such person has been acquitted or sentenced;

(4) Sentenced, when the sentence has been fully executed.

(c) *Revocation of consent.* An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and effective termination or revocation of such release from confinement, probation, or parole.

(d) *Restrictions on redisclosure.* Any information directly or indirectly received pursuant to this section may be used by the recipients thereof only in connection with their official duties with respect to the particular individual with respect to whom it was acquired. Such recipients may not make such information available for general investigative purposes, or otherwise use it in unrelated proceedings or make it available for unrelated purposes.

§ 2.39-1 Criminal justice system referral.—Basis and purpose.

(a) On the basis of extensive written comment and oral communications received on the subject matter of § 2.39 as proposed in the May 9, 1975 notice (designated as § 2.40 in that notice), we have concluded that the latitude allowed and the conditions imposed in § 2.39 as set forth above are necessary and proper to effectuate the purposes of the authorizing legislation.

(b) From a legal standpoint, it seems highly doubtful whether, in a proceeding to revoke probation or parole, the due process requirements laid down in *Morrissey v. Brewer*, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed.2d 484 (1972) and *Gagnon v. Scarpelli*, 411 U.S. 778, 93 S.Ct. 1756, 36 L.Ed.2d 636 (1973) could be met by an unsupported general evaluation by a

treatment program to the effect that a patient's status or progress in treatment was unsatisfactory. Thus, if such an evaluation were all that could be communicated by a program about a particular patient's conduct during the period he was in treatment, a condition requiring satisfactory participation in a treatment program would to all intents and purposes become unenforceable. Moreover, if it were held to be enforceable, the operative decision on the revocation issue would then be made by the program, arguably exacerbating rather than alleviating its role-conflict problem. It may thus be the part of wisdom to confess that some degree of role-conflict is inherent in the situation of any program which accepts criminal justice referrals. If so, the issue then becomes that of finding the most constructive way to handle the conflict, rather than a sterile and futile effort to avoid it altogether.

(c) We are persuaded that in many instances a prohibition on free communication between probation officers and drug abuse program counsellors would have profoundly deleterious effects on the rehabilitative process. Many probation officers bring to their work a high degree of training, professionalism, and experience. They are under no illusion that they are dealing with a clientele which will never stumble or relapse, and if they have the information necessary to intervene at an early stage of such an episode, their intervention can often make the difference between success and failure for the client.

(d) There is, however, nothing in these regulations which precludes treatment programs from entering into agreements or arrangements with agencies or institutions of the criminal justice system to regulate or restrict the subject matter or form of communications of information about patients. For example, such an arrangement might provide for free oral communication between counsellors and probation officers, while restricting formal written reports by the program to specified types of so-called hard data such as attendance and urinalysis results. In view of widely differing conditions and attitudes in various parts of the country, substantial variations in such arrangements are not only expectable but desirable.

(e) A further aspect of this matter, which was not adequately considered or dealt with in the May 9 proposal, is the impact which the rules laid down in § 2.39 have on the bail decision. There is a high correlation between the disposition of the application for bail and the type of sentence which may be meted out upon conviction. The contrast between the recidivism rates for those who receive treatment and supervision, as against those who simply receive the punishment of incarceration, is a powerful argument against restrictions which would tend to narrow the circumstances under which conscientious judges can grant bail.

(f) It must be emphasized that § 2.39 in no way reduces the necessity to obtain written consent from patients, whether

or not referred by the criminal justice system, before disclosures for the purposes here involved can be made by programs. We have been urged to make an exception from the requirement of § 2.31 in the case of parolees and probationers, but such an exception would be wholly unsupported by the authorizing legislation. In fashioning these regulations, it is not our privilege to adorn a tabula rasa according to our own predilections; rather, it is our duty to interlineate a statute with fidelity to its spirit, its terms, and its purposes.

§ 2.40 Situations not otherwise provided for.—Rules.

(a) *Criteria for approval.* In any situation not otherwise specifically provided for in this subpart, where consent is given in accordance with § 2.31, a program may make a disclosure for the benefit of a patient from the records of that patient if, in the judgment of the program director or his authorized representative appointed as provided in § 2.17, all of the following criteria are met:

(1) There is no suggestion in the written consent or the circumstances surrounding it, as known to the program, that the consent was not given freely, voluntarily, and without coercion.

(2) Granting the request for disclosure will not cause substantial harm to the relationship between the patient and the program or to the program's capacity to provide services in general.

(3) Granting the request for disclosure will not be harmful to the patient.

(b) *Circumstances deemed beneficial.* For the purposes of this section, the circumstances under which disclosure may be deemed to be beneficial to a patient include, but are not limited to, those in which the disclosure may assist the patient in connection with any public or private claim, right, privilege, gratuity, grant or other interest accruing to, or for the benefit of, the patient or the patient's immediate family. Examples of the foregoing include welfare, medicare, unemployment, workmen's compensation, accident or medical insurance, public or private pension or other retirement benefits, and any claim or defense asserted or which is an issue in any civil, criminal, administrative or other proceeding in which the patient is a party or is affected.

§ 2.40-1 Situations not otherwise provided for.—Basis and purpose.

(a) Section 2.40 is based upon § 1401.23 of the previous regulations, amended to reflect the expansion made by the change in the law with respect to the permissible scope of consensual disclosures.

(b) A strong case can be made for the proposition that § 2.40 should, in effect if not expressly, require a program to make any disclosure requested by a patient. The discretion vested in the program, it can be argued, is at best an expression of overprotective paternalism, and at worst, an invitation to programs to cover up material potentially embarrassing to themselves. Bearing in

mind, however, that persons who have obtained the type of treatment to which this part applies are more vulnerable to pressures of various kinds than are patients in general, it seems preferable to retain some responsibility on the part of the program to protect the best interests of its patients in this very sensitive area. This, like many other choices which these regulations reflect, is a determination which can be reviewed and revised from time to time in the light of experience.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.—Rules.

(a) *In general.* Disclosure to medical personnel, either private or governmental, is authorized without the consent of the patient when and to the extent necessary to meet a bona fide medical emergency.

(b) *Food and Drug Administration.* Where treatment involves the use of any drug, and appropriate officials of the Food and Drug Administration determine that the life or health of patients may be endangered by an error in the manufacture or packaging of such drug, disclosure of the identities of the recipients of the drug may be made without their consent to appropriate officials of the Food and Drug Administration to enable them to notify the patients or their physicians of the problem in order that corrective action may be taken.

(c) *Incapacitated persons.* Where a patient is incapacitated and information concerning the treatment being given him by a program is necessary to make a sound determination of appropriate emergency treatment, such information may be given without the patient's consent to personnel providing such emergency treatment.

(d) *Notification of family or others.* When any individual suffering from a serious medical condition resulting from drug or alcohol abuse is receiving treatment at a facility which is within the scope of this Part the treating physician may, in his discretion, give notification of such condition to a member of the individual's family or any other person with whom the individual is known to have a responsible personal relationship. Such notification may not be made without such individual's consent at any time such individual is capable of rational communication.

(e) *Record required.* Any program making an oral disclosure under authority of this section shall make a written memorandum showing the patient's name or case number, the date and time the disclosure was made, some indication of the nature of the emergency, the information disclosed, and the names of the individuals by whom and to whom it was disclosed.

§ 2.51-1 Medical emergencies.—Basis and purpose.

The provisions of § 2.51 are adapted from § 1401.42 of the previous regulations, and are based on subsection (b) (2) (A) of the authorizing legislation. The

provision in the previous regulations with respect to patients who may be incarcerated is now covered in § 2.33(b).

Paragraph (d) of § 2.51 is based upon the theory that the disclosure there allowed is of the patient's endangered condition, not his identity as a drug or alcohol abuse patient, and that the humanitarian necessity of such notification outweighs its potential for accidental violation of confidentiality.

§ 2.52 Research, audit, and evaluation.—Rules.

(a) *Research, audit, and evaluation.* Subject to any applicable specific provision set forth hereinafter in this subpart, the content of records pertaining to any patient which are maintained in connection with the performance of a function subject to this part may be disclosed, whether or not the patient gives consent, to qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner. For the purposes of this subpart and for the purposes of subsection (b) (2) (B) of the authorizing legislation, the term "qualified personnel" means persons whose training and experience are appropriate to the nature and level of the work in which they are engaged and who, when working as part of an organization, are performing such work with adequate administrative safeguards against unauthorized disclosures.

(b) *Use of disclosures of patient identifying information.*

(1) Where a disclosure made to any person pursuant to paragraph (a) of this section includes patient identifying information with respect to any patient, such information may not be further disclosed, and may not be used in connection with any legal, administrative, supervisory, or other action whatsoever with respect to such patient, except as provided in paragraphs (b) (2) and (b) (3) of this section.

(2) The inclusion of patient identifying information in any written or oral communication between a person to whom a disclosure has been made pursuant to paragraph (a) and the program making such disclosure does not constitute the identification of a patient in a report or otherwise in violation of paragraph (a).

(3) Where a disclosure is made pursuant to paragraph (a) of this section to a person qualified to determine, on the basis of such disclosure, the presence of a substantial risk to the health and well being, whether physical or psychological, of any patient, and, in the judgment of such person, such a risk exists and the situation cannot be dealt with solely by means of communications as described in paragraph (b) (2) of this section without intensifying or prolonging the risk as compared with other means of dealing with it, then the initial disclosure under paragraph (a) and any subsequent dis-

closure or redisclosure of patient identifying information for the purpose of reducing the risk to the patient involved shall be subject to the provisions of § 2.51.

§ 2.52-1 Research, audit, and evaluation.—Basis and purpose.

(a) *General purpose.* Subsection (a) of this section is adapted directly from subsection (b) (2) (B) of the authorizing legislation. The purpose of each is the same: To facilitate the search for truth, whether in the context of scientific investigation, administrative management, or broad issues of public policy, while at the same time safeguarding the personal privacy of the individuals who are the intended beneficiaries of the process or program under investigation. This subpart in particular, and this part as a whole, are intended to aid in carrying out that purpose.

(b) The succeeding sections of this subpart deal with problems which arise in connection with disclosures made for certain specific purposes which have been interpreted as falling within the general purposes embraced by § 2.52. Those sections will be best understood, however, in the light of some discussion of the underlying premises of the general rule, and its relationship to two other legal concepts: the right of privacy, and the duty to obtain informed consent from research subjects.

(c) *The Right of Privacy.* So far as is relevant to this discussion, we may consider the right of privacy in two aspects. One, a protection against improper governmental activity, is the right to be secure against unreasonable searches and seizures guaranteed by the Fourth Amendment, with some expansion from the penumbras of the Fifth and Sixth Amendments. The protections afforded to patients by the authorizing legislation, not to mention these regulations, go far beyond those which are constitutionally required.

(d) The other aspect of the right of privacy, which has sometimes been described as the right to be left alone, is the notion that an individual has a right not to be hurt by intrusions into his essentially personal concerns, or to have essentially private information exploited for commercial gain, whether or not the intrusion or exploitation is in connection with any possible governmental action against him. The courts have spoken of a right of privacy in a wide variety of contexts, but they have repeatedly and explicitly rejected the notion that anyone has a right to go about his daily affairs encapsulated in an impenetrable bubble of anonymity. The courts have been careful to weigh the competing interests, and the social interest in valid research and evaluation is clearly of sufficient moment to be considered in this process.

(e) In defense of the position that disclosure of patient identifying information even for carefully guarded scientific research should be permitted only on a consensual basis, two dominant lines of argument, somewhat interrelated, have emerged. One is that retrospective

studies are of questionable value in any case, and the other is that a sampling technique involving informed consent on the part of the members of the sample can always be used to develop the information sought. Neither line of argument will withstand careful scrutiny.

(f) It is true, of course, that the efficacy of a given therapeutic agent can often best be evaluated by means of a well-designed prospective study in which special recordkeeping procedures, special criteria for patient selection, and an appropriate control have all been established with a view to the purpose of the study. There are, however, many important investigations which simply do not lend themselves to such a format. Sometimes the desirability or even the possibility of a particular study does not suggest itself except in retrospect. Another important consideration is the fact that knowledge that an investigation is going on may influence the behavior of patients, clinicians, or both. Where such knowledge can influence the make-up of a sample, it will normally do so in the direction of favorable outcomes, but to an unknown degree, thus tending to invalidate the results reported.

(g) While the sample technique has its uses, especially with populations that are unmanageably large, it is often less difficult and expensive, and less likely to interfere with the actual conduct and outcomes of treatment or rehabilitation processes, to use the full population under study. Even more important than economy and administrative convenience in carrying out a study, there may be an overriding advantage in terms of eliminating any question as to the validity of the results of the study on the ground of bias in the selection of the sample.

(h) *Informed Consent.* The duty to obtain informed consent is obvious and compelling in situations where an individual is exposed to the possibility of harm, either physical or psychological, as a consequence of medical procedures, research, or similar activities. Where such a situation exists the person conducting the research or medical procedure violates his duty to the subject or patient if he proceeds without obtaining the voluntary informed consent from the individual or his legally authorized representative. Thus, in conducting an activity which places the subject or patient at risk the practitioner may not give precedence to a hidden agenda, even for so lofty a motive as the advancement of knowledge. In this regard, see the Department of Health, Education and Welfare's Protection of Human Subjects Regulations, 45 CFR Part 46. Those regulations are applicable to all Department of Health, Education and Welfare grants and contracts supporting research, development and related activities involving human subjects.

(i) It is apparent that the foregoing rationale for requiring informed consent does not apply to the same degree in situations involving the disclosure of clinical records for research in the form of follow-up or retrospective studies. Under these circumstances the risk to the

subject is that some disclosure or misuse of information from which he could be identified might result in embarrassment, lost opportunities, or other forms of psychological or social injury. While that possibility of harm could be reduced by requiring consent to every review of clinical records for research purposes, a similar result can be achieved by the less restrictive method of limiting further disclosure of identifying information by the researcher. Given the applicability of this alternative, equally effective means for protecting a patient or subject from the possibility of a harmful public disclosure, it is unreasonable to insist upon informed consent to every review of clinical records for the purposes of conducting legitimate research, particularly since such insistence could lead to the ultimate absurdity of prohibiting efforts to identify the nature and source of an unknown plague simply because the patients or researcher lacked the clairvoyance to have consent forms signed prior to the onset of the affliction.

(j) In sum, there are restraints on certain means of governmental acquisition of information about individuals which are operative irrespective of how the information is used, and there are restraints on the uses of information which are independent of how or by whom it is acquired, but they do not and should not add up to the proposition that the use of information about a person is either morally or legally the absolute prerogative of that person to determine.

(k) For all of these reasons, the authorizing legislation expressly provides that patient consent is not required with respect to disclosures for research, audit, and evaluation, nor does it prohibit individual patient identification in connection with such disclosures. While it is entirely appropriate to impose safeguards and procedures in connection with these activities, it would be wholly inappropriate to use the rulemaking process to impose an absolute requirement of patient consent with respect to activities which by statute may be conducted without it.

(l) *Classification of activities.* It is clear that Congress intended a balancing of the social interest in the validity of the results of inquiry, on the one hand, with the individual interest in anonymity, on the other, all within the limits set by the legislation and the constitution. With that objective in mind, we may now turn to the various categories of activities which come within the purview of this subpart.

(m) These activities may be classified first, in regard to whether participation is voluntary from the standpoint of the program, and second, as to whether the objective is to ascertain compliance with predetermined standards (examinations as defined in § 2.54, and program evaluation as defined in § 2.11(g)(1)), or to ascertain the validity of a given standard or hypothesis (scientific research, and program evaluation as defined in § 2.11(g)(2)). The application of the foregoing classifications logically results in

the creation of four categories of activities. Three of them are specifically dealt with in the succeeding sections of this subpart and need not detain us here; the fourth is discussed below.

(n) *Scientific research and evaluation.* Beyond the bare restatement of the authorizing legislation set forth in § 2.52, these regulations are deliberately silent with respect to purely voluntary scientific research and program evaluation in the sense defined in § 2.11(g)(2). Testimony and written comments received on the August 22, 1974 draft regulations were noteworthy in two respects. First, no instances of abuse on the part of persons acquiring patient identifying information under these circumstances were cited. Second, while there was some well-founded criticism of the attempt in that draft to provide guidelines for determining what is scientific research and who is qualified to do it, no usable alternatives—indeed, almost no alternatives at all—were forthcoming.

(o) In one of the written comments, the writer cautioned against any assumption "that our major remaining problems in drug and alcohol abuse treatment are prevention of illicit diversion and protection of confidentiality," and suggested "that we still have a problem in discovering, testing and evaluating improved treatment techniques. To do this," he continued, "one should place minimal obstacles in the way of bona fide clinical and epidemiologic research!"

(p) The result of leaving the rule as it is in the statute, without attempting to sharpen its outlines or define its terms, will be to leave it for interpretation on a case-by-case basis by those who must apply it in practice: the researchers who seek the information, and the programs which supply it. This does not foreclose the possibility of amending the regulations on the basis of experience if it appears either that clinicians are becoming so cautious that research and evaluation studies are being choked off, or that abuses are occurring in the use of information disclosed. But until a need for more detailed regulation in this area is demonstrated, we think its imposition would do more harm than good.

§ 2.53 Governmental agencies.—Rules.

(a) *In general.* Where research, audit, or evaluation functions are performed by or on behalf of a State or Federal governmental agency, the minimum qualifications of personnel performing such functions may be determined by such agency, subject to the provisions of this part, with particular reference to the organizational requirements and limitations on the categories of records subject to review by different categories of personnel.

(b) *Financial and administrative records.* Where program records are reviewed by personnel who lack either the responsibility for, or appropriate training and supervision for, conducting scientific research, determining adherence to treatment standards, or evaluating treatment as such, such review should be confined as far as practicable to adminis-

trative and financial records. Under no circumstances should such personnel be shown caseworker or counsellor notes, or similar clinical records. Programs should organize their records so that financial and administrative matters can be reviewed without disclosing clinical information and without disclosing patient identifying information except where necessary for audit verification.

(c) *Scientific research and long-term evaluation studies.* No State and no agency or political subdivision of a State may require, as a condition to funding, licensing, or otherwise, that any program furnish patient identifying information for the purpose of conducting scientific research or long-term evaluation studies unless the recipient of such information is legally required to hold such information in confidence, is prohibited from making any administrative, investigative, or other action with respect to any individual patient on the basis of such information, and is prohibited from identifying, directly or indirectly, any individual patient in any report of such research or evaluation, or otherwise disclosing patient identities in any manner.

(d) *Opinion and description to be furnished program.* Before any patient identifying information is required to be submitted by a program under the circumstances described in paragraph (c), the program shall be furnished—

(1) An opinion by the attorney general or other chief legal officer of the State to the effect that the conditions specified in paragraph (c) are fulfilled with respect to such program or with respect to all programs in such State similarly situated, and

(2) A description of the administrative procedures and physical limitations on access or other measures to provide for the security of the data, but such description shall not be in such detail as to furnish guidance for wrongful attempts to breach such security.

(e) *Exclusiveness of procedures.* No State or local governmental agency may require any treatment program to furnish patient identifying information to itself or any other recipient except in conformity with this section or § 2.54. No Federal agency may require any treatment program to furnish patient identifying information to itself or any other recipient except in conformity with this section (other than paragraph (d) (1) thereof) or § 2.54.

§ 2.53-1 Governmental agencies.—Basis and purpose.

Section 2.53 is an implementation of the authority contained in subsection (g) of the authorizing legislation to provide safeguards and procedures to effectuate the purposes of such legislation. It makes clear that whenever information is required of a program, whether by law or by the terms or conditions of a contract or grant, the procedures and safeguards required under this section are applicable.

§ 2.54 Patient identifying information in connection with examinations.—Rules.

(a) *Definitions.* For the purposes of this section—

(1) The term "examination" means any examination to which this section is made applicable by paragraph (b) of this section.

(2) The term "examiner" means any individual or any public or private organization, including any Federal, State, or local governmental agency, which conducts an examination to which this section applies.

(b) *Applicability.* This section applies to any examination of the records of a treatment program which is carried out for the purpose of or as aid to ascertaining the accuracy or adequacy of its financial or other records, or the efficiency or effectiveness of its financial, administrative, or medical management, or its adherence to financial, legal, medical, administrative, or other standards, regardless of whether such examination is called an audit, an evaluation, an inspection, or by any other name.

(c) *Statement required for disclosure of patient identifying information in connection with examination.* No program may make, and no examiner may require, any disclosure of patient identifying information in connection with an examination unless the examiner furnishes to the program a written statement—

(1) that no record of patient identifying information will be made or retained by or on behalf of the examiner in connection with the examination without notice to the program in accordance with paragraph (c) (2) of this section, or

(2) setting forth the specific purpose for which a record of patient identifying information is being retained, by or on behalf of the examiner, the location at which such information will be kept, and the name, official title, address, and telephone number of a responsible individual to whom any inquiries by the program about the disposition of such record should be directed.

(d) *Disposition of record of patient identifying information in connection with examination.* After any record of patient identifying information retained in connection with an examination has served its purpose, or within the time prescribed in paragraph (e) of this section, whichever is earlier, the examiner shall destroy or return to the program all records (including any copies thereof) containing patient identifying information which have been in its possession in connection with such examination.

(e) *Maximum time allowed for disposition.* The action required by paragraph (d) shall be completed—

(1) Except as provided in paragraph (e) (2) of this section not more than two years after the record was acquired by or on behalf of the examiner, or

(2) Where the record is needed in connection with a formal legal proceeding against the program commenced or to be commenced not more than two years after the record was acquired, and writ-

ten notice to this effect is furnished to the program within two years after the record was acquired, not later than the termination of such proceeding.

(f) *Notice of final disposition.* When an examiner disposes of records as required by paragraph (d) of this section, or not later than the time prescribed by paragraph (e) of this section, whichever is earlier, the examiner shall furnish to the program concerned a written statement—

(1) That there has been compliance with this section and with the provisions of this part prohibiting any disclosure of patient identifying information from records held by auditors or evaluators, or

(2) Specifying the particulars in which there has been a failure of compliance.

§ 2.54-1 Patient identifying information in connection with examinations.—Basis and purpose.

Confidence on the part of treatment program personnel in the integrity of auditing and regulatory processes is important to the effective functioning of the treatment system. It is the purpose of § 2.54 to foster practices which will both justify and engender such confidence.

§ 2.55 Supervision and regulation of narcotic maintenance and detoxification programs.—Rules.

(a) *Definition of "registrant".* For the purposes of this section, the term "registrant" means a person who (1) has pending an application for registration under section 303(g) of the Controlled Substances Act (21 U.S.C. 823 (g)), or (2) has been registered under such section and whose registration has not expired or been surrendered or revoked.

(b) *Drug Enforcement Administration.* Duly authorized agents of the Drug Enforcement Administration shall have access to the premises of registrants for the purpose of ascertaining compliance (or ability to comply) with standards established by the Attorney General under section 303(g) (2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) respecting the security of stocks of narcotic drugs and the maintenance of records (in accordance with section 307 of the Controlled Substances Act, 21 U.S.C. 827) on such drugs. Registrants shall maintain such records separate from and in addition to patients' clinical records required to be maintained under 21 CFR 310.50f (d) (7) (iii), which shall not be available to such agents except as authorized under a court order in accordance with Subpart E of this part. Records maintained by registrants for the purposes of section 307 of the Controlled Substances Act (21 U.S.C. 827) need not identify patients by name, address, social security number, or otherwise except by an identifying number assigned by the registrant, but where such a system is used, the registrant shall maintain on a current basis a cross-index referencing each identifying number to the name and address of the patient to whom it refers. Upon request at any time and without advance notice, but subject to the pro-

visions of § 2.54, such agents shall be granted immediate access to any such index. Such agents may use names and addresses so obtained strictly for the purposes of auditing or verifying program records, and shall exercise all reasonable precautions to avoid inadvertent disclosure of patient identities to third parties. Names and other identifying information so obtained may not be compiled or used in any registry or personal data bank of any description.

(c) *Food and Drug Administration.* Duly authorized agents of the Food and Drug Administration shall have access to the premises of registrants and to all records maintained by registrants, for the purpose of ascertaining compliance (or ability to comply) with standards established by the Secretary of Health, Education and Welfare under section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (42 U.S.C. 257a), sections 303(g)(1) and 303(g)(3) of the Controlled Substances Act (21 U.S.C. 823(g)(1) and 823(g)(3)), and sections 505 and 701(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 and 371(a)). When necessary in the conduct of their duties, and subject to the provisions of § 2.54, agents may use names and addresses of patients strictly for the purposes of auditing or verifying program records, and shall exercise all reasonable precautions to avoid inadvertent disclosure of patient identities to third parties. Names and other identifying information on patients obtained pursuant to this section or by any other compulsory process may not be compiled or used in any registry or personal data bank of any description. Except as authorized under this paragraph or by a court order granted under Subpart E of this part, (1) such agents may not, either orally or in writing, except in conversation with personnel of the registrant while on the premises of the registrant, identify any patient otherwise than by reference to an identifying number assigned by the registrant, and (2) such agents may not remove from the premises of the registrant any notes, documents, or copies thereof which contain patient identifying information.

(d) *State drug law enforcement agencies.* Duly authorized agents of any State drug law enforcement agency having jurisdiction and specific responsibility by statute or otherwise for the enforcement of criminal laws relating to controlled substances (as defined in the Controlled Substances Act) shall have access to the premises of any registrant for the purposes (with respect to corresponding provisions, if any, of State law) and subject to the restrictions and limitations set forth in paragraph (b) of this section, and subject to § 2.54.

(e) *State health authorities.*

(1) *Definition of "qualified State health agency".* As used in this paragraph, the term "qualified State health agency" means an agency of State government (i) which has express legal responsibility to ascertain that registrants under its jurisdiction comply with appropriate treatment standards; (ii)

which is legally and administratively separate from any agency of State government responsible for investigation of violations of, or enforcement of, criminal law generally or criminal laws relating to controlled substances; (iii) whose personnel are qualified by training or experience to conduct inspections of health care facilities to ascertain compliance with treatment standards; and (iv) whose personnel are by State law, or by published administrative directive enforced by effective sanctions, required to maintain the confidentiality of any information concerning the identity of patients which they may acquire in the course of their official duties.

(2) *Access.* Duly authorized agents of a qualified State health agency shall have access to the premises of registrants and to all records maintained by registrants, for the purpose of ascertaining compliance (or ability to comply) with treatment standards (including those relating to quantities of narcotic drugs which may be provided for unsupervised use by individuals in treatment) established under State law. Such access, and the use of any information thereby obtained, shall be subject to the restrictions and limitations set forth in paragraph (c) of this section, and subject to § 2.54.

§ 2.55-1 Supervision and regulation of narcotic maintenance and detoxification programs.—Basis and purpose.

(a) Section 2.55 is addressed to the general problem described in the following passage from the legislative history of Pub. L. 93-282:

A major element of the task of fashioning new regulations pursuant to the express rulemaking authority conferred by this legislation will be to reconcile the sometimes conflicting interests of research, audit, and evaluation with rights of privacy and the confidentiality of the relationship between patient and clinician. Such a reconciliation becomes particularly crucial where the functions of research, audit, or evaluation are conducted by a governmental agency with regulatory powers and responsibility, and the treatment involves the use of a drug such as methadone which is in a research status or which is readily susceptible of misuse or illicit diversion.

Because of the difficulty and complexity of the task, the rulemaking authority is intentionally cast in terms broad enough to permit the limitation of the scope, content, or circumstances of any disclosure under subsection (b), whether (b)(1) or (b)(2), in the light of the necessary purposes for which it is made or required. (Congressional Record, daily edition, May 6, 1974, page H3563).

(b) It has been the consistent interpretation of the Special Action Office for Drug Abuse Prevention that the only provision of the authorizing legislation which permits disclosures to compliance officers, whether of DEA, FDA, or state agencies, is subsection (b)(2)(B). That subsection strictly prohibits any further disclosure of names or other identifying information concerning patients, and the statutory prohibition has been buttressed by provisions of these regulations, notably § 2.54, providing safe-

guards and procedures to assure that the statutory prohibition is respected.

(c) In testimony and written comment on the August 22, 1974 draft of these regulations, it has been urged that access to patient identifying information by law enforcement personnel, even for the limited purposes allowed by statute and regulation, should be prohibited except pursuant to a court order obtained under 21 U.S.C. 1175(b)(2)(C). We believe that such a prohibition is beyond our power to impose.

(d) Section 307(b) of the Controlled Substances Act (21 U.S.C. 827) provides, in pertinent part, "Every . . . record required under this section . . . shall be kept and be available, for at least two years; for inspection and copying by officers or employees of the United States authorized by the Attorney General." It is a well known principle of statutory construction that amendments and repeals by implication are not favored. In *People v. Newman*, 32 N.Y.2d 378, 345 N.Y.S.2d 502, 299 N.E.2d 651 (1973), cert. denied 41 U.S. 1163, 94 S.Ct. 927, 39 L. Ed. 2d 116 (1974), the United States filed *amicus* briefs with the Court of Appeals of New York and with the United States Supreme Court, arguing that section 408 of Pub. L. 92-255 (21 U.S.C. 1175) did not effect an implied amendment or repeal of the provisions of Pub. L. 91-513 (21 U.S.C. 872(c) and 42 U.S.C. 242a(a)) which confer on the Attorney General and the Secretary of Health, Education, and Welfare the power to grant the so-called research privilege discussed in § 2.24. This position was expressly adopted by the New York court. We cannot now take the inconsistent position that section 408 of Pub. L. 92-255 did indeed amend by implication section 307 of Pub. L. 91-513, particularly in the face of a contrary contemporaneous administrative interpretation by both the Special Action Office for Drug Abuse Prevention and the Department of Justice. In short, if the right of access and copying conferred on Federal agents by 21 U.S.C. 827 is to be amended to provide that it may only be exercised pursuant to a court order in the case of maintenance and detoxification programs, that is a change which must be wrought by the Congress.

(e) In the case of inspections carried out by health supervisory agencies, we think that denial of access to any documents showing patient identifying information may have a serious adverse effect on the validity of the inspection process. Even if a program keeps its own records in terms of patient-identifying numbers assigned by the program, the patient file may contain—may, indeed, be required to contain—documents signed by the patient or originating outside the program. Where signatures, names, and addresses are all obliterated, it is impossible for the inspector to check the file even for apparent internal consistency. We believe that outright forgery is and will remain a rarity, but the temptation to cover improper or inadequate documentation by "accidental misfilings" may be something else again.

(f) From a legal standpoint, the term "audit" has long comprehended the notion of external verification. In a commercial setting, this means that at least some inventory will actually be counted, at least some receivables will be verified by contacting the customers, and so on. To rule that this crucial aspect of the audit process cannot be carried out with respect to a treatment program until after the auditor goes through the procedure of obtaining a specific court order under subsection (b) (2) (C) would seem to contravene the intent of subsection (b) (2) (B).

(g) In all of this, our decisions must be illuminated by a balanced consideration of the best interests of the patient no less than a desire to foster the implementation of cherished values in society at large. If protection of the patient's right to privacy is achieved by means which seriously impair our ability to protect him from exploitation and malpractice, not to mention the diversion of funds intended for his benefit, it would be a hollow victory indeed. We believe that the procedures and safeguards which these regulations impose on the conduct of audits and evaluations will avoid that result, while affording substantial and meaningful new protection to the confidentiality of patient records.

§ 2.56 Prohibition on disclosure of patient identities from research, audit, or evaluation records—Rules.

Where the content of patient records has been disclosed pursuant to this subpart for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, information contained therein which would directly or indirectly identify any patient may not be disclosed by the recipient thereof either voluntarily or in response to any legal process whether Federal or State. This prohibition does not affect the accessibility of the original records under authority of a court order referred to in subpart E.

§ 2.56-1 Prohibition on disclosure of patient identities from research, audit, or evaluation records—Basis and purpose.

Section 2.56 restates the prohibition on further disclosure which is contained in subsection (b) (2) (B) of the authorizing legislation. The relationship of the provisions authorizing court orders to the provisions authorizing disclosure for research, audit, and evaluation, is dealt with in § 2.62.

Subpart E—Court Orders

§ 2.61 Legal effect of order—Rules.

Subsection (b) (2) (C) of the sections which authorize this part (21 U.S.C. 1175 and 42 U.S.C. 4582) empowers the courts, in appropriate circumstances, to authorize disclosures which would otherwise be prohibited by subsection (a) of those sections. Subsection (b) (2) (C) operates only as a mechanism for the relief of the duty imposed by subsection (a) and not as an affirmative grant of jurisdiction to

authorize or compel disclosures prohibited or privileged by other provisions of law, whether Federal or State. An order or provision of an order based on some other authority, or a subpoena, or other appropriate legal process, is required to compel disclosure. To illustrate, if a person who maintains records subject to this part is merely requested, or is even served with a subpoena, to disclose information contained therein in a manner prohibited in the absence of a court order, he must refuse such a request unless, and until, an order is issued under subsection (b) (2) (C). Such an order would remove the prohibition, but could not, of its own force, require disclosure. If there were no subpoena or other compulsory process, or a subpoena had been issued but had expired or been quashed, the custodian of the records would have discretion as to whether to disclose the information sought unless and until disclosure were ordered by means of appropriate legal or administrative process, the authority for which would have to be found in some source other than subsection (b) (2) (C) of the sections authorizing this part.

§ 2.61-1 Legal effect of order—Basis and purpose.

(a) Section 2.61 is a restatement of the interpretative rules embodied in §§ 1401.61 and 1401.62 of the previous regulations. Both the positioning of the authority to issue court orders in S. 2097 as initially passed by the Senate (92nd Congress, 1st Session, December 2, 1971) and the explicit cross-reference in section 408(a) of Pub. L. 92-255 make clear the congressional intent that section 408(b) (2) (C) operate as a mechanism for the relief of the 408(a), strictures and not as an affirmative grant of jurisdiction to authorize disclosures prohibited by other provisions of law, whether Federal or State.

(b) The amendment made by Pub. L. 93-282 to section 333 of the Alcoholism Act (42 U.S.C. 4582) was enacted with the same language and structure as section 408 in this regard in order to make the interpretative rules set forth in § 2.61 applicable to it.

§ 2.62 Inapplicability to secondary records—Rules.

The authority which subsection (b) (2) (C) of the sections which authorize this part (21 U.S.C. 1175 and 42 U.S.C. 4582) confers on courts to issue orders authorizing the disclosure of records applies only to records referred to in subsection (a) of such sections, that is, the records maintained by treatment or research programs which have patients, and not to secondary records generated by the disclosure of the subsection (a) records to researchers, auditors, or evaluators pursuant to subsection (b) (2) (B).

§ 2.62-1 Inapplicability to secondary records—Basis and purpose.

(a) The interpretative rule set forth in § 2.62 is an essential and basic limitation on the scope of (b) (2) (C) orders. It was part of the original regulations under section 408 of Pub. L. 92-255 pub-

lished November 17, 1972 (37 FR 24338), and was carried forward unchanged in the amended regulations published December 6, 1973 (38 FR 33748), the special status of which has already been noted in § 2.3. See, also, § 2.61-1.

(b) Although this rule is well supported by the history and technical structure of the legislation, the policy considerations in its favor are even more compelling. In § 2.52-1, we have discussed the urgent necessity for access, even without patient consent, to patient records on the part of qualified personnel engaged in scientific research and evaluation. Where this access includes patient identifying information, as it sometimes must if vital work is to be done, there must not be any question whatsoever about the legal inviolability of its confidential status in the hands of the researcher. Granted, there may occur rare occasions when the original records are for some reason not available, where a (b) (2) (C) order would lie as to the original records, and where there would seem to be some advantage in the administration of justice for such an order to permit disclosure of identifying information by the researcher. But compared to the damage which the mere potentiality for access does to the whole research enterprise, the advantage in terms of ability to deal with rare and anomalous cases seems almost trivial. Even in those cases, denial of access to the party seeking the information leaves him in no worse position than if the research or evaluation, which was certainly not undertaken for his benefit, had never been done at all.

(c) Where the secondary records are generated under the circumstances described in § 2.54, of course, this argument does not apply. In that situation, if preliminary examination suggests that the records may be needed for compliance or other administrative or judicial proceedings, the person conducting the audit or other examination should promptly seek the authority of a court order to copy the original records. The use of secondary records thus generated under authority of a court order would then be limited by the terms and purposes of the order, rather than subsection (b) (2) (B) of the authorizing legislation, and thus the rule set forth in § 2.62 would not apply.

§ 2.63 Limitation to objective data—Rules.

(a) *Limitation to objective data.* Except as provided in paragraph (b) of this section, the scope of an order issued pursuant to this subpart may not extend to communications by a patient to personnel of the program, but shall be limited to the facts or dates of enrollment, discharge, attendance, medication, and similar objective data, and may include only such objective data as is necessary to fulfill the purposes for which the order is issued.

(b) *Exception.* When a patient in litigation offers testimony or other evidence pertaining to the content of his communications with a program, an order under this subpart may authorize

the submission of testimony or other evidence by the program or its personnel.

§ 2.63-1 Limitation to objective data.—Basis and purpose.

In the three-year period subsequent to the original enactment of 21 U.S.C. 1175, not a single occasion was reported to the Special Action Office for Drug Abuse Prevention on which an attempt was made to secure a (b) (2) (C) order authorizing the disclosure of a confidential communication by a patient to a counsellor or other member of the staff of a treatment program. In all of the comments and testimony received on the draft regulations published August 22, 1974, there was nothing to suggest any circumstances under which a court order authorizing such a disclosure would be either desirable or appropriate. Yet the mere possibility that such an order might be issued is to some a source of anxiety which impairs the effectiveness of treatment. Such an ongoing negative effect clearly outweighs the remote theoretical possibility that some peculiar circumstance might arise in which judicial authorization for such a disclosure might be sought. Accordingly, the limitation imposed by § 2.63 on the scope of (b) (2) (C) orders to preclude that possibility, and hence to eliminate its adverse influence on treatment services, appears to be a proper exercise of rulemaking power.

§ 2.64 Procedures and criteria in general—Rules.

(a) *Identity of patient.* Applications for court orders to authorize disclosure of records pertaining to a known patient shall not use the real name of the patient unless the patient consents thereto voluntarily and intelligently. In the case of an *ex parte* application initiated by the patient, the application should be instituted in the name of a fictitious person, such as Jon Doe, unless the patient requests otherwise. The same procedure should be followed in the case of a separate proceeding held in conjunction with a pending criminal or civil action. Any court order should identify the patient fictitiously, and the disclosure of the patient's real name should be communicated to the program in such manner as to protect the confidentiality of the patient's identity.

(b) *Notice.* In any proceeding not otherwise provided for in this subpart, in which the patient or the program has not been made a party, each shall be given appropriate notice and an opportunity to appear in person or to file a responsive statement, deposition or other form of response consistent with local rules of procedure. The court shall give due consideration to any such statement, deposition or other response in exercising its discretion as to the existence of good cause and, if deemed necessary or desirable, consistent with local rules of procedure, it may order the program director to appear and give direct testimony.

(c) *Hearings.* All hearings and all evidence in connection therewith shall be

held or taken in the judge's chambers, unless the patient requests an open hearing or the court determines that such hearing is consistent with the public interest and the proper administration of justice.

(d) *Good cause.* No order shall be issued unless the record shows that good cause exists, and in assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

(e) *Need for disclosure.* If other competent evidence or sources of information are available, the court should ordinarily deny the application.

(f) *Adverse effects.* If there is evidence that disclosure would have an adverse effect upon successful treatment or rehabilitation of the patient or would impair the effectiveness of the program, or other programs similarly situated, in the treatment or rehabilitation of other patients, the application should be denied unless the court finds that the adverse effects are outweighed by other factors.

(g) *Content of order.* Any order authorizing disclosure shall—

(1) Limit disclosure to those parts of the patient's record deemed essential to fulfill the objective for which the order was granted;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include any other appropriate measures to keep disclosure to a minimum for the protection of the patient, the physician-patient relationship and the treatment services.

(h) *Applications not otherwise provided for.* In any case not otherwise provided for in this subpart, application for an order authorizing disclosure of records to which this part applies may be made by any person who has a legally cognizable interest in obtaining such disclosure.

§ 2.64-1 Procedures and criteria in general.—Basis and purpose.

Section 264, in accordance with subsection (g) of the authorizing legislation, sets out procedures and criteria for the issuance of (b) (2) (C) orders in general, subject to the more specific provisions with respect to particular types of proceedings covered in the succeeding sections of this subpart.

§ 2.65 Investigation and prosecution of patients.—Rules.

(a) *Applicability.* This section applies to any application by an investigative, law enforcement, or prosecutorial agency for an order to permit disclosure of patient records for the purpose of conducting an investigation or prosecution of an individual who is, or who is believed to be, a present or former patient in a program.

(b) *Notice.* Except where an order under § 2.66 is sought in conjunction with an order under this section, any program with respect to whose records an order is sought under this section shall be notified of the application and

afforded an opportunity to appear and be heard thereon.

(c) *Criteria.* A court may authorize disclosure of records pertaining to a patient for the purpose of conducting an investigation of or a prosecution for a crime of which the patient is suspected only if the court finds that all of the following criteria are met:

(1) The crime was extremely serious, such as one involving kidnapping, homicide, assault with a deadly weapon, armed robbery, rape, or other acts causing or directly threatening loss of life or serious bodily injury, or was believed to have been committed on the premises of the program or against personnel of the program.

(2) There is a reasonable likelihood that the records in question will disclose material information or evidence of substantial value in connection with the investigation or prosecution.

(3) There is no other practicable way of obtaining the information or evidence.

(4) The actual or potential injury to the physician-patient relationship in the program affected and in other programs similarly situated, and the actual or potential harm to the ability of such programs to attract and retain patients, is outweighed by the public interest in authorizing the disclosure sought.

(d) *Scope.* Both disclosure and dissemination of any information from the records in question shall be limited under the terms of the order to assure that no information will be unnecessarily disclosed and that dissemination will be no wider than necessary. Under no circumstances may an order under this section authorize a program to turn over patient records in general, pursuant to a subpoena or otherwise, to a grand jury or a law enforcement, investigative, or prosecutorial agency.

(e) *Counsel.* Any application to which this section applies shall be denied unless the court makes an explicit finding to the effect that the program has been afforded the opportunity to be represented by counsel independent of counsel for the applicant, and in the case of any program operated by any department or agency of Federal, State, or local Government, is in fact so represented.

§ 2.65-1 Investigation and prosecution of patients.—Basis and purpose.

(a) The need for objective criteria for the issuance of court orders in connection with investigation or prosecution of patients seems particularly pressing. In the absence of such criteria, the assurance of confidentiality otherwise provided for by the authorizing legislation may be felt to be of little value.

(b) It has not been found possible to frame entirely satisfactory rules for the scope of orders under § 2.65, but an illustration may be helpful. Where a witness to a crime is believed capable of identifying a suspect by appearance, and the criteria set forth in § 2.65(c) are met, and the program has photographs of its patients, the witness alone may be permitted to view the photographs, with no names attached. If the witness failed to identify any photograph as being a pic-

ture of the suspect, that would end the matter. If there was such an identification, the program would be authorized to give any information in its possession as to the suspect's identity and whereabouts to appropriate authorities.

(c) It is not the purpose of this section to substitute a mechanical formula for judicial discretion, but rather to provide criteria which define the area within which discretion is to be exercised. The reason for including all crimes committed on program premises or against program personnel is not any special solicitude for programs as opposed to other victims of crime, but is rather the result of the special difficulties which the broad definition of "records" in § 2.11(o) creates for program personnel as complaining witnesses.

(d) In regard to § 2.65(e), experience has demonstrated that independent counsel may be of crucial importance. The leading case construing 21 U.S.C. 1175, *People v. Newman*, 32 N.Y.2d 379, 345 N.Y.S.2d 502, 298 N.E.2d 651 (1973); certiorari denied, 414 U.S. 1163, 94 S.Ct. 927, 39 L. Ed.2d 116 (1974), would never have been presented to the courts but for the fact that legal counsel for Dr. Newman was furnished on a *pro bono publico* basis by a private law firm. In an entirely different case, a United States District Court appears to have issued a wholly inappropriate order under 21 U.S.C. 1175 in a case in which the treatment program involved was operated by an agency of the United States Government, and either was unrepresented, or was represented by the same attorney who represented the agency seeking the order. It is possible, of course, that the order would have been issued in any event, but it seems clear that there was no adequate presentation to the court of arguments or testimony in opposition. It is difficult to see how the purposes of subsection (b) (2)(C) of the authorizing legislation can be carried out if there is inadequate presentation of the issues to the courts which must decide them.

§ 2.66 Investigation and prosecution of programs.—Rules.

(a) *Applicability.* This section applies to any application by an administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency for an order to permit disclosure of patient records or the making of copies thereof (including patient identifying information) for the purpose of conducting an investigation or an administrative or judicial proceeding with respect to any program or any principal, agent, or employee thereof in his capacity as such.

(b) *Notice.* An application under this section may, in the discretion of the court, be granted without notice, but upon the implementation of any order so granted, the program shall be afforded an opportunity to seek the revocation or amendment of such order.

(c) *Scope.* Both disclosure and dissemination of any information from the

records in question shall be limited under the terms of the order to assure that patient identities will be protected to the maximum practicable extent, and that names and other identifying characteristics of patients are expunged from any documents placed in any public record. No information obtained pursuant to an order under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65.

§ 2.66-1 Investigation and prosecution of programs.—Basis and purpose.

The principal purpose of § 2.66 is to enable a regulatory agency whose inspection or other source of information has disclosed a need for follow-up, or which has been refused access to patient records, to obtain the necessary authorization for access and copying. There may also be rare instances, such as those involving financial fraud, tax evasion, or other offenses where access by other investigative agencies is necessary, subject to the requirements and protections of this part.

§ 2.67 Undercover agents and informants.—Rules.

(a) *Applicability.* This section applies to any application by an administrative, regulatory, supervisory, investigative, or law enforcement agency for an order to permit such agency to have an undercover agent or informant in a program under circumstances which would otherwise be prohibited under § 2.19.

(b) *Notice.* An order under this section may be granted without notice where the criminal conduct for the investigation of which it is granted is believed to be carried on by the program director or by any employee or agent of the program with the knowledge of the program director or under such circumstances that in the exercise of reasonable care the program director should know of such conduct. Under any other circumstances, an order under this section may be granted only after the program director has been afforded notice and opportunity for hearing.

(c) *Criteria.* An order under this section may be granted only where there is reason to believe that a program or any principal, agent, or employee thereof is engaged in serious criminal misconduct, and that other means of securing evidence of such criminal misconduct are not available or would not be effective.

(d) *Scope.* An order granted pursuant to this section may authorize the use by the applicant of an undercover agent or informant, either as a patient or as an employee, of the program in question.

(e) *Time periods.* An order under this section may not authorize the use of an undercover agent for an initial period exceeding 60 days. At any time prior to the expiration of such 60-day period, the applicant may apply for an order extending such period for an additional period not to exceed 60 days, but in no event may the use of an undercover agent

in any program be authorized for more than 180 days in any period of 12 consecutive months.

(f) *Duty of agent.* Except to the extent expressly authorized in an order under this section, which shall be limited to disclosure of information directly related to the purpose for which the order is granted, an undercover agent or informant shall for the purposes of this part be deemed an agent of the program within which he is acting as such, and as such shall be subject to all of the prohibitions of this part applicable to disclosures of any information which he may acquire.

§ 2.67-1 Undercover agents and informants.—Basis and purpose.

The legal rationale underlying this section has been set forth in § 2.19-1. It is expected that this section will find its principal and perhaps its exclusive application in the area of drug law enforcement. Experience has demonstrated that medical personnel, no matter how credentialed, can engage in the illicit sale of drugs on a large scale, and that the use of undercover agents and informants is normally the only effective means of securing evidence sufficient to support a successful prosecution.

[FR Doc.75 17169 Filed 6-27-75; 9:38 am]

**Title 21—Food and Drugs
CHAPTER III—SPECIAL ACTION OFFICE
FOR DRUG ABUSE PREVENTION
PART 1401—CONFIDENTIALITY OF DRUG
ABUSE PATIENT RECORDS**

Revocation of Part

On May 9, 1975, there was published in the FEDERAL REGISTER (40 FR 20542) a notice of proposed rulemaking proposing the revocation of Part 1401 of Title 21 of the Code of Federal Regulations, by reason of the proposed incorporation of its subject matter in a new Part 2 of Title 42 of the Code of Federal Regulations.

Interested persons were invited to submit written comments, views, or arguments with respect to the proposed revocation, within 30 days of the date of publication of that notice. None were received, except to the extent that they were implicit in those submitted on the proposed new Part 2 of Title 42 of the Code of Federal Regulations, which were duly considered.

Accordingly, pursuant to the authority of section 408 of the Drug Abuse Office and Treatment Act of 1972, as amended by Pub. L. 93-282 (21 USC 1175), and under the authority delegated to the General Counsel (39 FR 17901, May 21, 1974), Part 1401 of Title 21 of the Code of Federal Regulations is revoked effective August 1, 1975.

Dated: June 25, 1975.

GRASTY CREWS, II,
General Counsel, Special Action
Office for Drug Abuse Prevention.

[FR Doc 75-17170 Filed 6-27-75; 9:38 am]

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METHODOLOGY

Interviewing simulations, lectures, videotape (or audiotape) demonstrations, discussions, and independent readings with maximum recommended ratio of trainer to trainees of 1 to 6

MATERIALS REQUIRED

- One Trainee's Manual for each trainee
- One Trainer's Manual for each trainer
- One demonstration videotape (or audiotape)
- Tests and training forms duplicated from Trainer's Manual

EQUIPMENT

- One ½-inch videotape playback system (or audio cassette playback system)
- Flip chart easels and pads, markers

TRAINING TEAM REQUIREMENTS

The training team as a whole should have the following qualifications: experience in training and in counseling in drug abuse treatment programs. Counselor training and extensive preparation in mental health care are desirable. (It is not necessary that each person on the training team have all these qualifications.)

FACILITIES NEEDED

- One large-group meeting area
- Two small-group work areas

TIME REQUIREMENTS

Seven 3½-hour sessions, either in one 3½-day period or spread over an extended period, as appropriate to program needs